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A PHENOMENOLOGICAL INVESTIGATION OF CLIENT PERCEPTIONS OF THEIR
RELATIONSHIPS TO CO-LEADERS IN PROCESS GROUPS

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of
Philosophy at Virginia Commonwealth University.

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Abstract

A PHENOMENOLOGICAL INVESTIGATION OF CLIENT PERCEPTIONS OF THEIR RELATIONSHIPS TO CO-LEADERS IN PROCESS GROUPS

By Benjamin T. Wood, M.S., M.T.S.

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2010

Director: Steven Danish, Ph.D.
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This dissertation examines the question *how do group therapy members perceive the therapeutic relationship in process group therapy?* The study fits within the interpretivist paradigm and employs a phenomenological qualitative research approach (Moustakas, 1994). The theoretical framework used to orient the study drew on process group theory according to Rutan, Stone, and Shay's (2007) psychodynamic group psychotherapy approach and Yalom and Leszcz's (2005) interpersonal process model of group psychotherapy. Participants were 10 university counseling center clients who were members of process therapy groups at a large urban university. Data collection consisted of in-depth interviews and demographic questionnaires. Phenomenological data analysis procedures followed recommendations by Creswell (2007) and Moustakas (1994). To enhance the rigor and trustworthiness of the study, the researcher engaged in member checking, use of an external auditor, reflexive and methodological journaling, and negative case analysis. Results of the study are presented as descriptions of how participants perceived the therapeutic relationship and the relationship's influence on the experience of group therapy. Eight categories emerged from the interviews: (a) presence of group leaders; (b) safety; (c) caring; (d)

sharing; (e) running the group; (f) levels of leadership; (g) developing understanding; and (h) intimacy with boundaries. Categories consisted of one or more related themes. There is a consideration of how the researcher's experiences and beliefs played a role in the study. The results are discussed in relation to relevant group therapy theory and research. Strengths, weaknesses, and considerations of the study findings are offered. Implications of the study findings for group therapy practice and research are noted.

Key words: group therapy, interpersonal process, phenomenology, therapeutic factors, interpretive, client perceptions, therapeutic relationship

A phenomenological investigation of client perceptions of their relationships to co-leaders in process groups

Therapists that facilitate process oriented psychotherapy groups believe that group members benefit from their interactions. In support of their beliefs, theoretical literature speculates on the ways in which therapists influence group members in process oriented groups (Rutan et al., 2007; Yalom & Leszcz, 2005). Empirical literature also indicates that the relationship between group members and therapists is associated with important treatment outcomes (e.g., symptom resolution) (Dies, 1983; 1994; Riva, Wachtel, & Lasky, 2004). Shockingly, no one has examined *how group members perceive* the nature of the therapeutic relationship in process-oriented group therapy in their own words. The aim of this dissertation is to examine this unexplored area of inquiry.

The therapeutic relationship is defined as the attitudes and feelings that clients and therapists have towards each other and the way in which they are expressed (Norcross, 2002). The theoretical literature on the therapeutic relationship in process group therapy has focused primarily on the perspectives of therapists. According to the theoretical literature, the therapeutic relationship in process-oriented group therapy is characterized by how therapists help promote therapeutic factors (Bernard et al., 2008; Rutan et al., 2007; Yalom & Leszcz, 2005). The literature does not take into consideration what group members have to say about the relationship.

Admittedly, there has been extensive empirical research examining the therapeutic relationship in group therapy. Reviews of the literature indicate that positive outcomes in group therapy are associated with clients having positive perceptions of their therapists (Dies, 1983; 1994; Riva et al., 2004). Yet, the data collected and analyzed in these studies are

constrained by how the researchers chose to characterize the relationships with quantitative assessments.

The nature of the theoretical literature and empirical research on the therapeutic relationship in process group therapy reveals the lack of knowledge regarding the perspective of group members. The examination of group member perspectives of the therapeutic relationship in process group therapy will provide information that will compliment the existing literature. This is a particularly relevant area of inquiry at the current time. Process-oriented group therapy is a treatment approach that is a common treatment for a population that has a growing demand for therapy services. The population mentioned are students seeking services in university counseling centers.

There is a growing demand for treatment in university and college counseling settings (Gallagher, 2009; 2008). Process group therapy is one treatment approach that is used to meet the demand. By the early 1990s, group therapy had become an essential treatment approach in university counseling centers (Golden, Corazzini, & Grady, 1993). A decade later, Kincade & Kalodner (2004) reasserted group therapy's importance within university counseling settings. They found that counseling centers offered a variety of group treatments to students, including process-oriented groups. Colbs (2003) reported that 81% of college counseling centers offered some form of group therapy to students and 32% of them offered process-oriented group therapy.

The growing number of students being treated with process-oriented group therapy underscores the need for a comprehensive understanding of the therapeutic relationship. More knowledge about the therapeutic relationship will help inform how therapists think about and provide treatment. A comprehensive understanding must take into consideration

the many roles that group therapists fulfill, the influence of the relationship on treatment outcomes, and *how group members perceive the relationship*. This dissertation contributes to the existing literature by examining group member perceptions of the therapeutic relationship in process-oriented group therapy offered at a university counseling center. The research questions for the dissertation are:

1. How do clients perceive their relationships with their group co-leaders?
2. How do the therapeutic relationships influence the clients' experience of group?

This study employs a qualitative phenomenological method to explore group therapy clients' perceptions of the therapeutic relationship. This method fits within the theoretical framework of the interpretative paradigm for social science research (Burrell & Morgan, 1979). Discussions of phenomenological qualitative research methods and the interpretivist paradigm are detailed below.

Recruitment procedures, data collection, and data analyses are discussed within the methods chapter. Study findings are presented as a description of the themes that emerged from individual interviews with 10 participants who were enrolled in process-oriented therapy groups at a university counseling center. Select quotes are provided to elucidate the experiences of the participants. Lastly, there is a discussion of the results in relation to the existing literature.

Literature Review

The literature review begins with an overview of group therapy within a university counseling setting. Thereafter, process-oriented group therapy is reviewed, focusing on Rutan, Stone, and Shay's (2007) psychodynamic group psychotherapy and Yalom and Leszcz's (2005) interpersonal process group psychotherapy models. Next, qualitative approaches to research are covered. There is a special emphasis given to why the interpretivist paradigm and a phenomenological qualitative method are appropriate to answer the research questions. Finally, the significance of the study is discussed.

Group therapy within college and university settings

Group therapy addresses a growing need for mental health treatment options for college and university students. In each decade since the 1960s there have been increases in the number of people with severe psychological problems attending universities and colleges (Kitzrow, 2003). Kristin (2007) found that students in the 2004-2005 academic year reported more anxiety and depression symptoms than those enrolled during the 1997-1998 academic year. Similarly, Benton et al. (2003) reported that, over a 13-year period spanning 1988 to 2001, there was a significant increase in 14 out of 19 client problem areas, including personality disorders, stress/anxiety, depression, relationship difficulties, family difficulties, and need for psychiatric medication.

Since the 1990s the number of students that seek mental health treatment from university and/or college counseling centers (herein referred to as *university counseling centers*) has increased (Kitzrow, 2003). A majority (93.4%) of counseling center directors reported an increase in students seeking mental health treatment with diagnosable mental

health difficulties (Gallagher, 2009). University counseling centers treated 10.4% of the student body in 2009 as compared to 9% in 2008 (Gallagher, 2009; 2008).

How can the needs of these students be met? Universities have tried several approaches, including offering prevention programs (Heppner & Neal, 1983), increasing the number of clinicians seeing students at university counseling (Gallagher, 2009), adopting a brief intervention model (Cooper & Archer, 1999), and wider use of group therapy approaches.

Though each of these approaches presents benefits and costs, group therapy is an attractive alternative treatment modality for university counseling centers. Group therapy has effectiveness comparable to individual therapy for a variety of difficulties for which students seek treatment, including relationship problems, anxiety disorders, mood disorders, and psychotic disorders (see Burlingame, Fuhrman, & Mosier, 2003; Cuijpers, van Straten, & Warmerdam, 2008; Gulmon, 2004; Halfhill, Sundstrom, Lahner, Calderone, & Nielsen, 2005; Kusters, Burlingame, Nachtigall, & Strauss, 2006; McDermut, Miller, & Brown, 2001; McRoberts, Burlingame, & Hoag, 1998; Payne & Marcus, 2008).

Group therapy uses fewer personnel and time and financial resources. One of the reasons behind the initial development of group therapy was that more people could be treated with fewer resources (Rutan et al., 2007). This theme remains dominant within a health-care culture that values reduced cost of treatment (Taylor et al., 2001). Thus, group therapy can help university counseling centers provide effective services to more clients, using fewer resources than individual therapy (Golden et al., 1993; McRoberts et al., 1998).

Process-oriented group therapy. A popular form of group therapy offered in university counseling settings is process-oriented group therapy (herein referred to as *process*

groups) (Colbs, 2003). Within university counseling centers, process groups typically run for 90 minutes, once a week, throughout the academic year (Golden et al., 1993; Colbs, 2003). Process groups focus on how clients use the relationships formed within groups to learn about themselves and to alter their relationship patterns outside of the context of the group (Yalom & Leszcz, 2005). Process groups are aimed at using relationships within the group to help group members develop self-awareness, reduce symptomatology, and build on strengths.

Not surprisingly, the therapeutic relationship in process groups is considered to be vital for clients to reach positive outcomes (Bernard et al., 2008). Before examining the role of the therapeutic relationship in process therapy, it is necessary to outline the processes by which group members make changes in group therapy.

Therapeutic factors in group therapy

There are many and varied ways in which people undergo change in group therapy. These include, but are not limited to, gaining insight into unconscious beliefs, being supported, and learning through education or modeling (Rutan et al., 2007). In order to clarify how change occurs, categories of therapeutic factors have been developed.

Yalom and Leszcz (2005) argue that positive change occurs in interpersonal process group therapy through multiple therapeutic factors. Successfully treated patients of this approach identified 12 factors as most to least important as follows (Yalom, Tinklenberg, J., & Gilula, M., 1968):

1. Interpersonal learning (input)
2. Catharsis
3. Cohesiveness

4. Self-understanding
5. Interpersonal learning (output)
6. Existential factors
7. Universality
8. Instillation of hope
9. Altruism
10. Family reenactment
11. Guidance
12. Identification

Because these factors are not always relevant to every group client, Mackenzie (1997) condensed the factors into four broad categories of therapeutic factors, including: (1) supportive, (2) self-revelation, (3) learning, and (4) psychological work.

The supportive factor occurs when people develop a feeling of safety (Rutan et al., 2007). Without a sense of safety, a client may not be able to engage in difficult psychological work. The supportive factor involves a sense of belonging in the group -- hopes are shared, acceptance is offered, universality is recognized, and/or cohesion among group members develops (Mackenzie, 1997). This is an important factor during initial phases of group when trust and safety are key issues (Yalom & Leszcz, 2005; Rutan et al.).

Self-revelation includes catharsis and self-disclosure during which clients reveal some aspect of themselves to other group members (Mackenzie, 1997). Catharsis is defined as a form of affective self-revelation in which clients purge emotions (Yalom & Leszcz, 2005). In contrast, self-disclosure is a cognitive-focused form of self-revelation (i.e., a client sharing how she thinks about herself with the group) (Rutan et al., 2007). Self-revelation

occurs when a sense of safety and support has developed. Positive experiences with self-revelation may lead to a further sense of support (Yalom & Leszcz).

Learning occurs in a variety of ways within process-oriented group therapy (MacKenzie, 1997). Clients may offer tips or advice to each other about how to cope with different problems; they may also imitate behaviors of therapists or other clients (Yalom & Leszcz, 2005). Therapists often take on a didactic role at the start of a group to teach members about appropriate ways of communicating and interacting (Rutan et al., 2007). Vicarious learning may also occur as clients watch other people work through issues (Rutan et al.).

Although support, self-revelation, and learning all have places within process groups, Rutan et al. (2007) identify psychological work as the primary therapeutic factor. Psychological work occurs when clients increase their self understanding through interpersonal learning and insight (Mackenzie, 1997). Examining interpersonal patterns of relating helps clients develop a sense of how they interact with others and how others respond to them (Yalom & Leszcz, 2005). Insight can occur in examinations of patterns of relating in the group or interpreting transference reactions (Rutan et al.). With increased self-understanding, clients develop a capacity to choose consciously a way of being in the world rather than being driven by unconscious dispositions (Rutan et al.).

Research on therapeutic factors within process groups suggests that not all therapeutic factors are beneficial to all clients in group treatment (for comprehensive reviews see Fuhriman & Burlingame, 1994; Kivlighan & Holmes, 2004). Kivlighan and Holmes hypothesize that therapeutic factors differ depending on client dimensions of affiliation (i.e.,

friendly to hostile) and control (i.e., dominant to submissive). Certain therapeutic factors may also be more salient at different times depending on the stage of group development.

There is a general consensus that there are five stages of group development: forming, storming, norming, performing, and adjourning (Bernard et al., 2008; Tuckman, 1965; Wheelin, Davidson, & Tilin, 2003). During the forming stage, group members begin to express their anxieties about joining the group and engage tentatively in self-disclosure. In the storming stage, group members confront each other and the group leaders to test and establish a sense of safety in the group.

Storming is followed by the norming stage, in which the group develops a sense of cohesion and a willingness to engage in the tasks of the process group. Groups reach the performing stage when they are able to analyze group-as-a-whole processes in addition to recognize individual processes. Performing is often characterized by members giving each other feedback openly. The adjourning stage can be experienced by the group-as-a-whole or by an individual leaving a group. Members often focus on the loss of the group and the relationships they have formed, while at the same time solidifying what they have gained from the experience.

The stages of group development may not necessarily be linear. Thus, different therapeutic factors will be beneficial to different group members depending on their personal style and the developmental stage of the group (Bernard et al., 2008; Kivlighan & Holmes, 2004). Bernard et al., in their clinical guidelines for the practice of group therapy, suggest that group therapists must facilitate the group members towards beneficial therapeutic factors while considering the developmental stage of the group.

Therapeutic relationships in process groups: Theory and research

The relationship between group therapists and group members plays a vital role in process groups (Bernard et al., 2008). Group members interact differently with different members and also present themselves differently within the group (Rutan et al., 2007). Therapists often serve as examples to imitate or role models with which to identify. Yalom and Leszcz (2005) identify therapists as the catalysts for promoting therapeutic factors by using interventions within the umbrella of the therapeutic relationship. The literature suggests that therapists promote four categories of therapeutic factors: support, self-revelation, learning, and psychological work.

Promoting support. Group therapists have a responsibility to help group members feel supported and safe (Yalom & Leszcz, 2005). In general, people are hesitant to engage in group therapy and may be apt to terminate prematurely (Dies, 1994). Ogrodniczuk, Piper, and Joyce (2006) found that 23% of group therapy clients terminated from group therapy prematurely. Because clients are hesitant to engage in group therapy, group therapists must work to create a sense of support and safety.

Researchers have tried to identify what makes clients feel safe. In a review of 135 studies on various forms of group therapy (e.g., T-groups, process groups, cognitive-behavioral groups, encounter groups, & theme groups) Dies (1994) found that when client's viewed group therapists negatively, they were more likely to terminate prematurely and/or be harmed by the group experience. Riva et al.'s (2004) review of studies examining leadership within group therapy found similar results. Conversely, when clients experience therapists positively they are more likely to stay in group, report positive treatment outcomes, and feel more comfortable engaging in the therapeutic factors (Dies, 1994; Riva et al., 2004).

Theoretical literature points to ways in which groups therapists can operationalize the vague concept of “being experienced positively.” One important task is for therapists to prepare the client for group treatment (Rutan et al., 2007). This duty includes educating clients about the frame of group (e.g., session length & limits of confidentiality), since having more knowledge helps clients feel safer about engaging in group therapy (Yalom & Leszcz, 2005). A recent systematic review of empirical research on pre-group preparation suggests that, with more preparation, there is enhanced cohesion and a decreased risk of premature dropout (Riva et al., 2004).

Therapists also promote support by building therapeutic alliances with the new clients (Yalom & Leszcz, 2005). The therapeutic alliance helps clients commit to and benefit from individual therapy (Bordin, 1979; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The alliance is also vital within group therapy (Bernard et al., 2008). The therapeutic alliance consists of three different dimensions: (1) bond, (2) task, and (3) goal agreement (Bordin, 1979). In order to form therapeutic alliances with the clients, therapists must connect affectively with them. They must also agree on the tasks of therapy (i.e., what is done and said in group therapy) and the goals for treatment.

Although there is theoretical support for the concept of the therapeutic alliance in group therapy, empirical research has not supported this view. In a review of thirteen group therapy studies that examined the relationship between the therapeutic alliance and treatment outcomes, there were no consistent positive alliance-outcome associations (see Abougouendia, Joyce, Piper, & Ogrodniczuk, 2004; Constantino et al., 2007; Cortez-Ison, 1997; Crowe & Grenyer, 2008; Joyce, Piper, & Ogrodniczuk, 2007; Lorentzen, Sexton, & Høglend, 2004; Piper et al., 2005; Schwartz, 2004; Sexton, 1993; Taft et al., 2003; van Andel

et al., 2003; Westerman, Foote, & Winton, 1995; Woody & Adesky, 2002). These results call into question the validity of using a construct like the therapeutic alliance, initially developed for individual therapy, to conceptualize the nature of the therapeutic relationship in group therapy.

Another way in which therapists promote support is by building cohesion among group members (Bernard et al., 2008). Yalom and Leszcz (2005) define cohesiveness as “the attractiveness of a group for its members” (pg. 55). Research suggests that cohesion among group members leads to a greater sense of safety than client-therapist relationships (Dies, 1994). Cohesion helps group members work together even during times of stress and strain within the group (Rutan et al., 2007). Therapists promote a sense of cohesion by providing a therapeutic environment in which group members experience a sense of trust and safety (Bernard et al.). Trust is developed by establishing and enforcing boundaries that protect confidentiality (Rutan et al.).

Promoting self-revelation. Therapists promote self-revelation in group therapy by engaging in clarification processes (Rutan et al., 2007). The goal of clarification is to gain a better understanding of an issue a client is discussing within the group (Rutan et al.). Therapists may ask clients to expand on what they have been discussing or to talk about how they are feeling. A variety of interventions can accomplish this task including commenting on non-verbal behavior (e.g., quickly tapping a foot when certain topics are discussed) or by asking clients to engage in using “I” statements (Yalom & Leszcz, 2005; Rutan et al.).

Therapists have the duty of encouraging group members to engage in beneficial forms and refrain from destructive forms of self-revelation. As an example, cathartic self-revelation may or may not be helpful to group members. As noted above, Yalom and Leszcz

(2005) identified catharsis as an affective form of self-revelation. According to the theoretical literature, it may help clients express affect that can later be analyzed within an interpersonal environment (Rutan et al., 2007; Yalom & Leszcz). Moreover, research suggests that clients enjoy engaging in catharsis (Yalom, Tinklenberg, J., & Gilula, M., 1968). Yet, there are possible drawbacks. For instance, Yalom (1966) found that clients that engage in catharsis, when they are new to group, are at risk of terminating prematurely. Therapists must consider whether certain types of self-expression will be beneficial for clients to engage in (Yalom & Leszcz).

Promoting learning. Much of the learning that takes place in group therapy occurs among group members (Yalom & Leszcz, 2005). However, therapists must promote an environment that encourages learning. This often takes the form of therapists encouraging clients to ask other clients how they solved a problem (Rutan et al., 2007). This is an important component of creating a sense of support and safety for new clients.

One specific form of learning that group therapists promote occurs during pre-group preparation (Rutan et al., 2007). During pre-group preparation, therapists educate clients about how often the group meets, how many people come to the sessions, the limits of confidentiality, and grounds for expulsion from the group (Yalom & Leszcz, 2005). Pre-group preparation is essential for clinical practice because it informs group members how to make use of group (Bernard et al., 2008). It also increases a sense of safety and reduces premature dropouts (see Dies, 1994; Riva et al., 2004).

Promoting psychological work. Group therapists promote psychological work among group members in a variety of ways including processing within the here-and-now and analyzing the transference through interpretation. Yalom and Leszcz (2005) assert that

process groups differ from other types of groups (e.g., cognitive behavioral groups, 12-step groups, psychoeducational groups) because of the focus on processing within the here-and-now (i.e., process illumination). “Here-and-now” refers to a focus on talking about immediate interactions and interpersonal patterns rather than historical information. Yalom and Leszcz are hesitant to define “process,” but they suggest that it refers to a developing sense of how group clients interact with each other within group and with people outside of group.

Process illumination has two components:

1. It occurs when group members see how interpersonal interactions influence perceptions.
2. Once an awareness of the influence of interpersonal interactions arises, group members can then process interactions in the here-and-now, thereby gaining insight into their interpersonal patterns and character (Yalom & Leszcz).

Group leaders promote process illumination by focusing group discussions on here-and-now interactions (e.g., “I noticed you rolled your eyes when client X was talking, tell us about that”). Therapists can also help clients identify characteristic ways they interact with other group members. Rutan et al. (2007) argue that by engaging in process illumination, group clients are able to work through their concerns and develop greater understanding of their psychologies. Processing has been identified as a key component to effective group therapy work (Bernard et al., 2008).

Process group therapists also help promote psychological work by interpreting the transference. Within process groups, interpretation consists of making what is unconscious, conscious, whereby it is possible to attach meaning to behaviors, feelings, or events (Rutan et

al., 2007). Interpretations occur in multiple forms including group-as-a-whole interpretations, leader-directed interpretations, and group-directed interpretations depending on the transference that is most salient to interpret at the time (Rutan et al.).

Freud (1940/1989) was the first to articulate the importance of the transference. He considered transference the primary focus of psychoanalysis and interpreting the transference as the primary agent of change. Transference refers to a process in which a person displaces feelings toward others onto the therapist. Initially, theorists and clinicians assumed that transference within group therapy should be initiated and interpreted as it was in psychoanalysis (i.e., with a specific focus on interpreting client transference reactions to a group analyst, *leader-directed*) (Wolf & Schwartz, 1962).

However, over time other aspects of transference were recognized as important to interpret within group therapy (Rutan et al., 2007). *Group-as-a-whole* transference refers to how the whole group can develop a transference reaction towards a group therapist, often in the form of a parental transference (Bion, 1960). *Group transferences* refer to transferences that occur between clients within the group (Rutan et al.).

Unlike psychoanalysis, interpreting the transference between an individual group member and a therapist within group therapy is not always the most important interpretation (Rutan et al., 2007). Group therapists must make transference interpretations of subgroups (i.e., clients that develop a bond together that sets them apart from the group-as-a-whole), individual members, and the group-as-a-whole in a fashion that is helpful (Bernard et al., 2008).

Group therapists must also act as containers for negative transference reactions (Bernard et al., 2008; Kernberg, 1998). To accomplish this task, group leaders respond to

negative transference reactions in a consistent and non-judgmental way so that group members can feel safe to explore their reactions. For instance, a male group therapist may be experienced as an uncaring, albeit powerful, father figure within the group. It is the group therapist's duty to help the group members learn about their transference reactions without punishing them for being upset with him. This may involve the group members expressing negative feelings towards the group therapist. Interpretation can be beneficial if the reactions are analyzed without condemning the clients for having them. Because of the status of the group leader, many group clients have transference reactions related to power struggles and parental dynamics (Rutan et al., 2007). There is the opportunity for them to work through these dynamics if group therapists are able to remain constant (i.e., non-judgmental and non-condemning) in the face of the negative transference reactions (Bernard et al., 2008).

Structural considerations

When investigating the therapeutic relationship in process group therapy at a university counseling center, it is important to consider structural influences on the relationship. Three structural considerations include shared leadership, training groups, and transferring leadership.

Shared leadership. The number of group therapists in a process group alters the nature of client-group therapist relationships. It is common in university counseling centers for there to be two group therapists leading a process oriented group (Golden et al., 1993). There are benefits to running a group with multiple therapists. Co-therapists can model how to resolve interpersonal differences (Getty & Shannon, 1969). With several therapists, there is less of a chance that an important dynamic is missed. Multiple therapists can offer support to each other when they are in need of assistance (Demarest & Teicher, 1954). Having

multiple therapists eliminates problems with coverage if one therapist is absent (Yalom & Leszcz, 2005). Co-therapy is also a helpful training technique. Being able to practice group therapy with an experienced clinician provides a richer learning experience to therapists in training, when compared to learning about group therapy in courses (Yalom & Leszcz).

Additionally, co-therapists can promote working through transference reactions. For instance, the group-as-a-whole may develop a positive transference for one group therapist and a negative transference for a second therapist (Kernberg, 1998). When such a dynamic occurs within group, it is possible for the group leaders to “work the object” such that they can use the positive transference directed at one therapist to help the group members understand the negative transference directed towards the other (Demarest & Teicher, 1954; Kernberg; Yalom & Leszcz, 2005).

The literature on group therapy clearly indicates that there are advantages to co-therapy. Nonetheless, it is important to note that co-therapy has its disadvantages. It may inadvertently lead all the group therapists to taking a break because each assumes another therapist is paying attention (Rutan et al., 2007). The group can suffer if the co-therapist relationship is not built on trust and support (Yalom & Leszcz, 2005). If co-therapists model a dysfunctional way of relating, clients may adopt a similar dysfunctional approach. Co-therapy may lead to positive or negative experiences depending on the nature of the relationship between the therapists (Rutan et al.).

Training groups. Similar to co-therapy, having therapists in training facilitate groups introduces another variable that influences the therapeutic relationship. At university counseling centers, training therapists are often paired with experienced therapists to facilitate a group (Yalom & Leszcz, 2005). By having an experienced therapist with a

therapist in training, training is provided and clients are treated ethically and competently (Yalom & Leszcz; Rutan et al., 2007). This model may introduce difficulties into the group because the experienced therapist often evaluates the therapist in training. This could cause a rupture in the relationship between the therapists which in turn, could cause tension within the group. In general, group members may become aware of the differential power dynamics. Such awareness may influence group member perceptions of the therapeutic relationship. For instance, they may respond by valuing the contributions of the experienced therapist while devaluing the contributions of the therapist in training (Rutan et al.).

Transferring leadership. Another event that can influence a therapy group is related to when a therapist leaves a group. The loss of a therapist is often difficult for group members (Chiang & Beck, 1988). Change in leadership can occur at a university counseling center at the start of new semesters when course schedules may change and prevent continuity with the original group that a student was participating in. Rutan et al. (2007) encourage therapists to be open about the impending loss of a therapist so that group members can process the loss.

Summary

Process groups are a popular form of group therapy offered at university counseling centers (Colbs, 2003). Group therapists have the responsibility of conducting a process group that promotes therapeutic factors for the group clients with a consideration of group development (Bernard et al., 2008). To do this, group therapists must interact with group members in a variety of ways including providing support, encouraging self-disclosure, promoting learning, and engaging in psychological work (MacKenzie, 1997; Rutan et al., 2007; Yalom & Leszcz, 2005). There is both theoretical and research support recognizing

the importance of the therapeutic relationship in group therapy (Dies, 1994, Riva et al., 2004; Rutan et al.; Yalom & Leszcz). Unfortunately, little attention has been paid to how group members perceive the relationships. The question remains: How do group members perceive their relationships with group therapists? A phenomenological qualitative research design from the interpretivist paradigm is an appropriate methodology to begin to answer this question.

Qualitative research

Group member perceptions of the therapeutic relationship in process group therapy have not been investigated in depth. The proposed dissertation aims to address this gap in the literature. There is a lack of qualitative research examining group therapy clients' perceptions of group therapists in process group therapy. Thus, it is necessary to give an overview of the qualitative approach employed in the dissertation.

Qualitative research is often employed when the questions being asked by researchers are aimed at gaining a thick (e.g., multilayered, embracing complexity) description of experiences in order to initiate learning about a phenomenon (Heppner, Kivlighan, & Wampold, 1999; Kazdin, 2003). It is a relevant approach when researchers want a more complex understanding of an issue than quantitative methods afford (Creswell, 2007). The aim of much qualitative research is to describe and clarify the lived experience of the people being researched (Polkinghorne, 2005). Even though qualitative research does not always have the aim of testing hypotheses, qualitative methods can be useful for generating hypotheses.

Ponterotto (2005) identified four paradigms used for scientific research including (1) positivism, (2) post-positivism, (3) constructivism-interpretivism, and (4) critical-ideological.

Positivism is the research paradigm for most quantitative research methodologies. It is founded on the principles of objectivity, use of the hypothetico-deductive method, a focus on discovering laws that allow explanation and prediction, and the use of large sample sizes to identify rules within populations as opposed to individual variances (Ponterotto).

Post-positivism rose in reaction to the rigidity of the positivistic paradigm. In opposition to positivism, there is no assumption that an ultimate truth can be measured. The post-positivists often focus on falsifying theory as opposed to verifying it (Ponterotto, 2005). Even so, post-positivism retains the goal of explanation and prediction.

Constructivism-interpretivism holds that there is no true objective reality; there is only the reality that is created by an individual in response to her environment. Meaning is made through deep reflection that often involves dialogue between a participant and an interviewer, in which both people co-create the data from the dialogue (Ponterotto, 2005). The subjective experience and construction of meaning is what is valued. The paradigm focuses on giving in-depth understandings and descriptions as opposed to discovering laws. It often relies on inductive and emergent reasoning as opposed to deductive reasoning.

Finally, the critical-ideological paradigm holds the goal of disrupting the status-quo (Kincheloe & McLaren, 1994, 2000; 2005). Within the critical-ideological paradigm the researcher's values are used to help guide the process of change. Researchers operating within the critical-ideological paradigm recognize that values are socially constructed, that certain parties have more privileges than others, and an important goal is to emancipate those with fewer privileges (Ponterotto).

In addition to the four research paradigms summarized by Ponterotto, he also reviewed five philosophical constructs that he identifies as frames of reference to understand

the paradigms. The five constructs are (1) ontology, (2) epistemology, (3) axiology, (4) rhetorical structure, and (5) methodology. These constructs exist on continua. A brief outline of these constructs is necessary.

1. Ontology is the study of the nature of reality and exists on a continuum with the poles spanning from naïve realism (e.g., positivist) and critical realism (e.g., post-positivist) to relativism (e.g., constructivist-interpretivist) (Ponterotto, 2005).

2. Epistemology is the study of the relationship between participant and researcher; the continuum of epistemology falls between dualism-objectivism (e.g., positivist) and subjective-transactional relations (e.g., constructivist-interpretivist) (Ponterotto, 2005).

3. Axiology identifies the influence of researcher values on the study with a continuum including no room for values (e.g., positivist), an inability to divorce values from the research (e.g., constructivist-interpretivist), to embracing values (e.g., critical-ideological) (Ponterotto, 2005).

4. Rhetorical structure refers to how the results and methods are presented. Rhetoric falls along a continuum of precise, objective, third-person language (e.g., positivism) to personalized, acknowledgement of biases, first person language (e.g., constructivist-interpretivist) (Ponterotto, 2005).

5. Finally, methodology is the design and process with which the research is completed. The continuum of methodology lies between strict scientific procedures with controlled variables and in-depth explorations of dialogues (e.g., positivist) and experiences that researchers and participants share, out of which the data emerges (e.g., constructivist-interpretivist) (Ponterotto, 2005). For further explanation of the research paradigms and related philosophical constructs please refer to Ponterotto.

Burrell and Morgan (1979) offer a complementary framework with which to understand research paradigms within the social sciences. They identified four paradigmatic stances that exist along two dimensions. The first dimension is subjectivity to objectivity. Subjectivity focuses on the importance of subjective experiences as creators of the social world. Objectivity focuses on a social world that is understood to be objective in reality. With this assumption, universal laws can be made to understand the processes in action (Burrell & Morgan). The second dimension is sociology of radical change to sociology of regulation. Sociology of regulation focuses on explaining the current state of affairs; whereas, sociology of radical change looks to find ways to make changes (Burrell & Morgan).

The four paradigms that Burrell and Morgan (1979) identify are radical humanist, radical structuralist, functionalist, and interpretivist. Radical humanist and radical structuralist focus on making changes. However, the radical humanist paradigm is subjective and the radical structuralist paradigm is objective. Ponterotto's (2005) critical ideological paradigm partially overlaps with the radical paradigms labeled by Burrell and Morgan.

Burrell and Morgan's (1979) functionalist and interpretivist paradigms fall on the regulation side of the radical change-regulation dimension; both of these paradigms are invested in describing what exists. They differ along the subjectivity-objectivity dimension with the interpretivist paradigm falling on the subjective side and the functionalist paradigm falling on the objective side. Ponterotto's positivist and post-positivist paradigms overlap with the functionalist paradigm of Burrell and Morgan. Additionally, Ponterotto's constructivist-interpretivism paradigm overlaps with Burrell and Morgan's interpretivist paradigm.

The dissertation is set within the interpretivist paradigm. It aims at gaining an in-depth understanding of group therapy clients' perception of their relationships to group therapists in process group therapy. This is in contrast to previous research that fits within the functionalist paradigm and employs positivist research methods (see Dies, 1994). The interpretivist paradigm is an appropriate stance for this project because the intent of the research is to describe experiences of the participants in depth. It is focused on regulation as opposed to radical change. Additionally, it falls on the subjective side of the subjective-objective dimension because I believe that each participant has unique experiences to contribute to the research.

In terms of ontology, the study holds a relativistic position in that there is no one truth to be discovered. As for epistemology, the study focuses on subjective relations. For axiology, I recognize that I will not be able to divorce my values completely from the research, though I attempt to bracket them. Consequently, I employ a rhetorical structure that is personalized, acknowledges biases, and uses first person language. Finally, the methodology is focused on describing the experiences that researchers and participants co-create within a phenomenological research approach.

Phenomenology. I chose a phenomenological research approach for the dissertation for the following three reasons. First, phenomenological qualitative research methods fit within the interpretivist paradigm employed in the study (Burrell & Morgan, 1979; Ponterotto, 2005). Second, phenomenological approaches are helpful when the research question focuses on describing participants' experiences of a common phenomenon (Creswell, 2007). Third, phenomenological approaches are particularly useful when studying relationships between clients and therapists (Ponterotto, Kuriakose & Granovskaya, 2008; Wertz, 2005).

Phenomenology comes from the Greek words φαίνω (phaino) meaning to bring to light and λόγος (logos) meaning the word, knowledge, or study (Liddell & Scott, 2000). Hence, phenomenology is the study of bring things to light, of understanding a phenomenon. The purpose of phenomenology is to take people's experience of a shared phenomenon and discover the universal essence of that experience (Creswell, Hanson, Clark & Morales, 2007). A principle goal of phenomenology is to describe the point of view of participants of the phenomenon being studied (Moustakas, 1994). With this goal, there is an absence of common research practices such as testing hypotheses, creating theories, or generalizing results to other populations (Wertz, 2005).

Though there is more than one approach to conducting phenomenological research in psychology (see Giorgi & Giorgi, 2008), there are two positions that orient research within a phenomenological lens (Wertz, 2005). The two positions are bracketing and a commitment to description. Bracketing involves the process by which researchers attempt to suspend their prior knowledge and assumptions about a phenomenon being studied in order to avoid imposing an order on the phenomenon (Wertz). The commitment to description entails a research approach that aims to describe the phenomenon of study as the participants experience it (Wertz). Consequently, it does not fit the phenomenon within a theoretical or hypothesized relation; it aims to describe the phenomenon in and of itself. Description can be generated from various data sources including oral or written text that the researcher identifies as a means of data collection (Morrow, 2007; Wertz). The specific phenomenological approach employed in the study is discussed in the methods section.

Significance of study

The dissertation is the first of its kind to gather detailed descriptions from clients regarding their perceptions of their relationships with group leaders in process groups at a

university counseling center. Theory posits that group therapists must form therapeutic relationships with their clients in order for them to engage in the therapeutic factors of process groups (Bernard et al., 2008; Rutan et al., 2007). Additionally, the empirical literature reveals that when clients perceive group therapists positively they tend to report positive outcomes (Dies, 1994; Riva et al., 2004). Nonetheless it is unclear how clients in process groups make sense of their relationship with their group therapists.

To correct this omission, the study used individual interviews to generate descriptive data regarding the participants' perceptions of their relationships with their group co-leaders and the influence of the relationships on their experience of group. This phenomenological approach helps generate information that is currently unknown. In this vein, there were no research hypotheses to be tested; rather, two research questions were asked.

1. How do clients perceive their relationships with their group co-leaders?
2. How do the therapeutic relationships influence the clients' experience of group?

Offering thick, detailed descriptions of the phenomenon of client-group therapist relationships can help clinicians, theorists, and researchers understand the clients' perspectives on the relationships. With greater understanding it is possible to further refine research foci and clinical approaches within process group therapy.

Method

The dissertation is set within the interpretivist paradigm and thus the design of the study fits the ontological, epistemological, axiological, rhetorical, and methodological assumptions congruent with the interpretivist paradigm (Burrell & Morgan, 1979; Ponterotto, 2005). With a focus on how knowledge is constructed through dialogue between individuals, semi-structured in-depth interviews were used as a means of data collection concerning clients' perceptions of their relationships to their group co-leaders. Interviews were conducted until the point of saturation. I employed specific strategies in order to bolster the trustworthiness, or in other words, the scientific rigor of the study. Additionally, approval for the study was attained through Virginia Commonwealth University's (VCU) Institutional Review Board before the study began. The dissertation employed a phenomenological approach to the design of the study that guided both the data collection and analysis methodologies.

Data collection

The primary vehicle for data collection was semi-structured individual interviews. Four data collection methods were considered when deciding upon a specific means of collection including observation, focus groups, written essays, and individual interviews. Observation offers a unique form of generating data (Angrossino, 2005), but there are limits to being able to gain a thick description of a phenomenon. Focus group interviews were also considered because they would allow for a parallel to the group dynamic experienced in session during the interviews (Kamberelis & Dimitriadis, 2005). However, one drawback identified to using this approach was that participants may influence how they describe their relationships to different treatment team members because of pre-existing relationships in the

group setting. Additionally, there were concerns about confidentiality. Written essays are another means to gather a concrete description of a phenomenon (Giorgi & Giorgi, 2008). Nonetheless, it was deemed that individual interviews would offer more flexibility in terms of gaining in-depth descriptions as compared to a focused written essay.

Individual interviews are common data collection methods for phenomenological researchers (Wertz, 2005). Nonetheless, phenomenological researchers have varying viewpoints on whether to use unstructured interviews or semi-structured interviews. Unstructured interviews are comprised of open-ended questions that are used in order to allow the dialogue regarding the phenomenon of interest to take any direction that is necessary in order to get a thick description of the phenomenon (Moustakas, 1994). In contrast, semi-structured interviews that start with open-ended questions and are followed by probe questions can be employed to help the interviewer focus the participant to share information about their lived experience as opposed to theories or opinions that reflect on that experience (Wertz).

It is important to note that the semi-structured approach is flexible enough to incorporate different probe questions as the interviews progress in order to gain a fuller description of the phenomenon (Wertz, 2005). A semi-structured interview was adopted for the study to ensure that the interviewer could focus the participants on describing their perceptions of their relationships to their group co-leaders. The interview for the study is described in more detail in the measures section.

Interviewer

The interviewer is both a co-creator of dialogue with the participants and a facilitator of the interview (Smith & Osborne, 2003). Interviewers have the role of interacting with

participants in such a way as to develop rapport, communicate respect, offer empathy, and direct the dialogue to gain concrete descriptions of the phenomenon of study. The principal researcher conducted the interviews for the study. Because of the interviewer's personal experience with being a process observer and co-leader of interpersonal process groups it gave him an advantage in terms of being familiar with the phenomenon being studied. Caution was taken to curtail assumptions about the phenomenon that could adversely influence the course of the study because of prior knowledge and experience (Marshall & Rossman, 2006). Procedures were adopted to take caution and these are outlined below.

Setting

All the participants for this study were Virginia Commonwealth University students who were currently in one of the counseling center's process oriented therapy groups. The center runs a variety of process oriented groups throughout the academic year, serving as the primary vehicle for long term therapy at the center. Group sessions at the center run for 90 minutes and meet weekly.

The university counseling center houses a group training program in which psychology and psychiatry practicum therapists learn about becoming group leaders. Typically groups are run by a team of two speaking leaders and one non-speaking process observer. Process observers are silent members that record process notes for the sessions. Following the conclusion of the group, they engage in a post-processing discussion of what they witnessed with the speaking leaders. Group members are allowed to observe the post-processing but they are not allowed to speak. The process observer also writes a weekly process summary note so that clients can read and recall what happened during the previous session. There is a licensed therapist that also serves as a supervisor and co-therapist for a

therapist in training (e.g., a psychology intern or psychiatry resident). Though this is a typical group leadership team model (see Yalom & Leszcz, 2005), groups may have only one speaking leader and they may have no process-observer depending on availability.

There are a variety of staff members at the center who run process-oriented groups. Yet, they all operate from a similar process-focused framework in the groups. They engage in the same pre-group preparations and set the same group boundaries. Clients often stay within the same group over the course of several semesters, schedule permitting. However, they may transfer to other groups if schedule conflicts arise.

Participants

Participants were 10 clients from Virginia Commonwealth University's University Counseling Services (UCS) who attended one of the center's outpatient process psychotherapy groups. Participants were included in the study if they were current clients in one of these groups. Before being included in the study, the participants had to attend three group sessions; this allowed for participants time to have developed an idea of their relationships with the group therapists. Participants were excluded from the study if they were not legally able to manage their own affairs, not yet 18 years of age, not able to speak or read English, were severely cognitively impaired, and/or were unable to grant informed consent. These parameters were set in order to promote a degree of consistency in the sample, an important factor when examining shared experiences of a phenomenon.

A purposeful data sampling plan was employed (Creswell, 2007) using convenience techniques in order to generate a study sample that represented clients in process psychotherapy groups at UCS. The purposeful sampling plan focused on recruiting participants that varied both in terms of their demographic characteristics and by group

leaders. Out of the 33 people that expressed a willingness to participate, 10 participants that represented different demographic characteristics (e.g., race, gender, major) and interacted with different group leaders completed the interviews.

Unlike positivistic research approaches, the sample was not formed to be generalizable (i.e., large sample sizes representing a normal distribution). The data sampling plan allowed for the study sample to consist of participants who could offer unique perspectives on the therapeutic relationship in group therapy. An important aspect of the data sampling was an intentional sampling of participants who had formerly been group members in a process group that I had co-led and of participants who had not been in group therapy with me. I thought that this would add another dimension to the descriptions of the therapeutic relationship. It is important to note that none of the participants were currently in group therapy with me.

The number of participants in the study was determined using the aid of the concept of saturation. Saturation is defined as collecting data until no new information is gained from continued collection (Creswell, 2007). Saturation often occurs in phenomenological studies with 5-25 participants (Creswell). I determined that saturation was met with 10 participants because no new themes emerged from the interviews. The presence of saturation was bolstered because similar themes arose from participants representing different demographic backgrounds and different relationship constellations with group leaders (e.g., having a single leader versus having multiple leaders).

Procedures

Recruitment of clients from the process groups at UCS was approved by the director of the clinic and the director of group training at UCS. The recruitment process was

conducted in three steps. First, I asked group co-leaders to ask participants if they would agree to me visiting during the first five minutes of their group session in order to discuss the study and request participation. Second, for groups willing to hear my request, I attended the first five minutes of the groups during which I informed the group members of the basic focus of the study and asked for participation. I distributed a sign-up sheet to gather contact information from interested members. Third, I used the contact information to contact the potential participants in order to set up a time to offer informed consent and conduct the interview. Participants were contacted either by email or phone, depending on their specified preference. During this initial contact, the prospective participants were screened to determine whether they were eligible for the study. If eligible, interview times were established.

Informed consent meetings and interviews were conducted in secure study rooms at Cabell Library. The reasons for choosing the location were threefold: (1) the participants knew the location and thus it was convenient and familiar; (2) private study rooms offered assurances for confidentiality; and (3) having the interviews at a neutral location allowed for the participants to share openly because the location was not relevant to the topic (Marshall & Rossman, 2006). It was thought that participants would not require compensation or incentive to participate in the study.

During the informed consent meeting, the interviewer offered a written consent form that contained the procedures of the study in addition to the specifications of confidentiality. The overview of the study was conveyed during the consent process and contact information was requested to complete the member-checking portion of the study (detailed below). Consent was established before the beginning of each interview. Before each interview began, the participants also filled out a brief demographic form. By having the participants fill out the written

questionnaire before the interview it was possible to catch problems such as missing data (Aronson, 1994). After the demographic form was completed, the interview was conducted. The interviews followed a semi-structured format and the interviewer asked follow-up questions as needed. Interviews were digitally recorded so that they could be transcribed. The total informed consent and interview meeting time lasted no longer than 90 minutes for each participant. Following the interviews, I transcribed the interviews and saved them in a Microsoft Word document with password protection. The use of the transcripts for data analysis is detailed below.

Measures

Data were collected through interviews and a background questionnaire in order to assess the research questions. The background questionnaire contains questions related to demographics, length of participation in group therapy at UCS, estimated length of time working with current therapists, number of therapists, and presenting problem (please see Appendix 1 for a copy of the background questionnaire).

The semi-structured interview consisted of four stem questions that focused on gaining participant descriptions of their experience of relationships to group leaders in process groups (please see Appendix 2 for a copy of the interview stem questions). I employed the questions and associated probes to generate a dialogue during the interviews that focused on concrete descriptions of the therapeutic relationships in group. I developed the questions by drawing upon personal experience with group therapy, a review of the literature, and discussions with people experienced in group therapy and qualitative research.

Although having a general framework to follow, I used other questions and probes if they were deemed necessary to promote the description of the phenomenon. The participants had the freedom to describe their relationships to group co-leaders and how this influenced

their experience of group therapy as they saw fit. With this freedom it was possible for themes and sub-themes to emerge over the course of the interviews. This flexible approach to conducting interviews is consistent with phenomenological interview methods (Moustakas, 1994).

Data analysis – quantitative

Descriptive statistics were generated from the background questionnaire in order to give a demographic profile of the participants in the study. The only quantitative analyses were those that helped represent the demographics of the sample.

Data analysis – qualitative

I used a phenomenological qualitative approach to analyze the data. Wertz (2005) offers counseling psychologists an outline of principles to employ for phenomenological data analysis including preparatory operations, attitude, analyzing individual descriptions, and grasping general structures. Preparatory operations help researchers become familiar with the data in order to begin the process of interpreting the meaning of what is communicated (Wertz). These operations include listening to and transcribing the interviews to gain a sense of the whole message conveyed. Thereafter, interviews are broken down into meaning units. Meaning units are created from the larger dialogue of the interview and are broken down into units that held meaning by themselves.

Attitude refers to phenomenological researchers adopting an empathic attitude towards the data (Wertz, 2005). Researchers are encouraged to set aside their own beliefs, values, and opinions, in order to empathize with the description provided by the participants. It is a focus on the meaning of the phenomenon within the frame of the interview.

Analyzing individual descriptions consists of examining distinct units of meaning that make up the larger lived experience conveyed by the participants (Wertz, 2005). These individual units of meaning must be analyzed in order to gain a general understanding of what is described. This process includes identifying how the phenomenon being studied differs from the participants' overall lived experience (Wertz). The researcher then identifies the parts that make up the experience of the phenomenon. Thereafter, the researcher identifies how these parts interrelate. Throughout this process the researcher attempts to identify the psychological processes that underlie the parts (Wertz). Researchers may also engage in an analysis of how their own experiences may influence the data analysis.

Grasping general structures follows the analysis of individual descriptions. The goal of this stage of the analysis is to identify the psychological structures and general meaning of the phenomenon. This is done via various procedures including comparing features in one case to determine if similar features appear in other cases (Wertz, 2005). This helps to identify a common essence of meaning from the data regarding the phenomenon and it also identifies knowledge that is not experienced by everyone (i.e., a knowledge of types) (Wertz).

Although offering principles of data analysis to guide the research process, Wertz (2005) does not outline a specific data analytic plan. Therefore, I will outline the specific data analytic plan of the study. The plan is listed in a general temporal order but these processes overlapped during the data analytic period.

The specific data analytic plan adopted for the study was Creswell's (2007) modified version of the Stevick Colaizzi-Keen phenomenological analysis and representation approach presented by Moustakas (1994). This approach was chosen because it fit within the

interpretivist paradigmatic framework and upheld the general assumptions of phenomenological research in counseling psychology. The modified version was used because the original version was created for multiple researchers to participate in the data analysis. Although there is an auditor of the research process as described below, I was the primary researcher conducting the data collection, analysis, and report.

The six-step approach offered by Creswell (2007) is as follows:

1. Researcher description of personal experience with the phenomenon (Creswell, 2007). I described my experience of the phenomenon in order to attempt to bracket my personal experiences and assumptions so that the focus of the data analysis can be on the participants instead of my own experiences. This description was referred to and expanded upon throughout the data analysis phase so that I could continue to be aware of my personal experience and its possible encroachment on the data analysis. It was not possible to separate my experience completely from the data analysis, but it was important to limit my own judgments when trying to understand the experiences of the participants.
2. Developing a list of significant statements (Creswell, 2007). This step in the data analysis involved several sub-steps. After the interviews were transcribed, I read them to get a sense of both the content of the interviews and the context presented in them. I then re-read a hard copy of the interviews in order to identify significant statements about how the participants experience the phenomenon. Significant statements are the meaning units described by Wertz (2005). Notes were recorded in the margins to identify the significant statements. The significant statements could consist of a phrase, a paragraph, or just a word; nonetheless, they were all discrete units of meaning.

Statements that were not relevant to the study were also identified during this process. I identified irrelevant statements as those that did not focus on any aspect of the participant's perceptions of the therapeutic relationship. A list of possible irrelevant statements was compiled and then they were compared to significant statements. If the statements continued to bear no relevance to the topic when comparing them to the significant statements, they were removed from further data analysis.

After this process, I engaged in *horizontalization* of the significant statements. Horizontalization consists of taking the list of significant statements and treating them as statements of equal value. With horizontalization one must form "nonrepetitive and nonoverlapping" statements (Creswell, 2007, pg. 159). Moustakas (1994) used the term horizontalization because the boundaries between each significant statement are akin to horizons.

To facilitate the process of horizontalizing the significant statements, I unitized the statements as described by Miles and Huberman (1994). Unitizing is the process by which the significant statements are identified and then separated as text by themselves. I accomplished this by highlighting discrete significant statements, which I subsequently printed onto cardstock. I cut each significant statement out of the cardstock sheets in order to have separate pieces of cardstock detailing the statements. Therefore, each piece of cardstock recorded one significant statement. I also labeled each cardstock piece by line number in the interview and by participant using different colors of cardstock (i.e., the participants had their own color cardstock). This made it possible to recall the context in which the statement was made in an interview.

3. Develop themes using the significant statements (Creswell, 2007). By reading and re-reading the significant statements I generated an initial list of themes. These were written down once they were recognized in the data. I also physically placed significant statements that had similar themes together and noted the clusters of statements (Miles & Huberman, 1994). Significant statements could be part of several different themes at the same time and these overlaps were noted in the methodological journal which will be described below. Multiple themes were identified and then subsumed into other themes and some themes fit within overarching categories. At the end of this process of identifying themes, I briefly described the meaning of the themes. Theme identification was complete once all data relevant to the phenomenon was accounted for by the themes and all the significant statements were classified within the themes.
4. Write the textural description (Creswell, 2007). The textural description consists of reporting *what* the participants experienced with the phenomenon. Transcript from the interviews is employed to elucidate what was experienced.
5. Write the structural description (Creswell, 2007). The structural description entails describing *how* the participants experience the phenomenon. The structural description provides contextual information regarding the phenomenon to help describe the experience of the phenomenon more fully. Contextual information was noted when relevant to describing the themes.
6. Write the textural-structural (i.e., essence) description (Creswell, 2007). The goal of writing the textural-structural description is to describe the essence of what and how the participants experienced the phenomenon. It is a synthesis of the textural and structural descriptions of the themes regarding the phenomenon. I wrote a textural-structural

description of each theme in order to convey the essence of what the participants experienced.

Data management

Qualitative studies employing interviews have the possibility of generating large amounts of confidential information that need to be stored safely. In order to protect confidentiality the participants were assigned a number that corresponded to their names. This number was used on all data forms (e.g., questionnaires, cardstock pieces, interview transcripts) apart from the consent form. All interviews were transcribed into Microsoft Word and password protected. These documents are saved on a secure server. Interview transcripts and cardstock pieces were produced in duplicate and locked in a file cabinet owned by the researcher. The digital recordings were burned onto compact discs and these discs are also saved in the file cabinet.

Trustworthiness and reflexivity

Trustworthiness is to qualitative research as validity is to quantitative research. When trustworthiness is present there is credibility in the product. There are no set definitions of trustworthiness in qualitative research and no standards to achieve them within a particular qualitative approach (Creswell, 2007). Writing to counseling psychologists, Morrow (2005) argued that it is important to develop trustworthiness for a qualitative study within the paradigmatic framework that is used. Therefore, I attempted to achieve trustworthiness in the study through the use of multiple strategies that fit within the interpretivist paradigm and more specifically, a phenomenological approach.

I employed the following trustworthiness strategies: clarifying researcher bias, auditing/peer debriefing, negative case analysis, and member checking (Creswell, 2007;

Morrow, 2005; Padgett, 1998). Clarifying researcher bias consists of acknowledging prior experience and biases regarding the phenomenon of study. This is offered at the outset so that readers understand how my experience has shaped the interpretation of the data. This was completed by the bracketing process described above in which I outlined my thoughts and experiences regarding the phenomenon being studied. I used a reflexive journal as an aid to this process. Reflexive journals are used to log ideas and personal reactions to the process of developing, implementing, and reporting on the study. I used and referred to my reflexive journal throughout the study in order to help bracket my personal experiences.

It is also important to limit researcher bias when conducting interviews. This was accomplished by following a semi-structured interview and refraining from leading questions. I also reviewed interviews before the next interview in order to identify any researcher bias that emerged in the interviews.

Auditing or peer debriefing requires having someone not part of the research study perform an external check on the research process and product. I fulfilled this trustworthiness strategy in two ways. First, I employed an audit trail using a methodological journal in which I logged all the methodological choices and procedures I used during the data collection, analysis, and report (Morrow, 2005). Though the purpose of phenomenological research is not to have a study that can be generalized, an audit trail allows for other researchers to conduct a study in a similar fashion and to check on whether I followed appropriate procedures.

Second, I worked with a peer auditor who was familiar with my research topic and the process in which I researched the topic. She is a current graduate student in psychology and she has experience with phenomenological research. She played the role of the devil's

advocate in order to ask hard questions about my methods and my interpretation of the data (Creswell, 2007). She also followed the audit trail and checked to see whether she could get to the same conclusions that I did by following my methodological approach. The goal here is not to see if the auditor gets equivalent findings, but rather that she sees coherence in my approach and my results (Churchill, Lowery, McNally, & Rao, 1998).

Negative case analysis entails refining the interpretation of the data using information that can disconfirm tentative conclusions that have been drawn (Creswell, 2007). I formulated rival themes and assessed the text in order to determine if these themes explained the evidence more coherently than the other themes that emerged from the data. This also helped in the process of bracketing researcher bias by pushing me to form alternative ideas about the data instead of becoming fixed on one point of view.

Member checking is defined as asking for the participants to check the results of the study in order to see if they find the results to be credible (Padgett, 1998). In phenomenological research there is a goal of attempting to describe accurately the experience of the participants. By checking with participants it is possible to see if they recognize the descriptions produced. During the initial interview I asked the participants if they were willing to be contacted to participate in the member checking process after I engaged in analyzing the data. If they agreed at the initial interview, I collected their contact information (i.e., phone number and email address) and I requested that they get in touch with me if their contact information changed. I contacted the participants to see if they were interested in hearing about the results of the study once I analyzed the data. I provided them with descriptions of the themes that emerged from the interviews. I also asked them if they

saw other themes that were missing or if the identified themes did not fit with their experience.

I sent an email to the 10 participants with an attached word document containing descriptions of each theme. I asked the participants to read the descriptions and to tell me whether the descriptions fit with what they experienced, if I missed anything, and if something was described incorrectly. Out of the 10 participants contacted, four responded. Three participants wrote back that they agreed with the themes and did not have anything else to add.

One of them wrote, "Everything that I read seems right on point." A second participant wrote, "This looks fine." The third participant wrote the following:

I thought you did a fantastic job representing my voice in the interview description document you attached to your message. I would say: 1) yes, the descriptions fit with what I've experienced, 2) no, you're not missing anything, at least from my perspective, and 3) no, nothing appears incorrect to me. I know this isn't much feedback, but I hope you found it useful.

The fourth responder offered a specific comment about the categorization of my themes. There was a comment in the document questioning whether the theme of *listened to* fit in a category I had labeled as *acceptance*. The participant offered these comments:

I feel these descriptions fit well with how I feel about group. I didn't see anything that bothered me or felt like it was out of step with what I described to you. I noticed the note in the "Listened to" section about possibly adding it to the "Accepted" category. I feel that the feeling of being listened to goes much further than being accepted. It can also re-affirm the trust relationship that I form with the group leaders if for some reason I feel like it has been damaged (for example, if we have been away

for winter/summer breaks). It also makes it easier to share something that might be hard to share, even if that was after I felt like I was accepted into the group. I've experienced many cycles of revealing things to the group, and each time the attentive listening of the group leaders helped me share.

This feedback was very helpful and I incorporated it into my analyses.

Specifically, I agreed with the participant that *listened to* did not fit within the *accepted* category. In fact, I no longer felt that there ought to be an *accepted* category and that the themes within it were more appropriate for other categories such as *sharing* and *safety*. I also incorporated the participant's new comments about being listened to within that theme. Out of these responses, I considered that the data-analyses represented the experience of the participants and that they were ready to be reported. The study findings are presented in the next chapter.

Study findings

The study findings are organized into four sections. First, I will share the bracketing of my assumptions in order to clarify the lens through which I conducted the study. Second, I will present descriptive statistics regarding the sample. Third, overviews of the 10 participants and their impressions of the therapeutic relationship in group therapy are offered. For certain participant profiles, quotes are documented to convey their experience of the therapeutic relationship in their own words. Fourth, the categories of themes that emerged from the data analysis are described including pertinent quotes.

Bracketing researcher assumptions

As noted above, I chose to bracket my experience before the description of the study findings so that readers can be aware of how my own experiences, values, and biases might have influenced the data analysis. It was also important to engage in this process so that I could be aware of how I might be biased in my approach to the study. There is no assumption that a researcher is bias-free within a phenomenological approach (Ponterotto, 2005). However, it is important for the researcher to be aware of his own subjective experience in order to see how it might influence the research. I do not believe that I eliminated the influence of my bias, but the process aided in limiting it.

Within the interpretivist paradigm, researcher assumptions, beliefs, and responses to the data must be recorded and considered throughout the research process. I employed methodological and reflexive journals over the course of the study to aid the bracketing process. This section records my personal experiences with the phenomenon of the therapeutic relationship in group therapy along with my reactions to the study.

Previous experience with the phenomenon. I have not been a client in a process group therapy. However, I participated in a group therapy training experience in which I was

on a leadership team for a process group. My experience with process group therapy consisted of taking a seminar course in which students learned about the theories and techniques used in process group therapy. There was also an experiential component to the course. For the first year of training, I was a process observer. It was my role to bear witness to how group members and group therapists related to each other. I noticed how some members became more attached to particular therapists and less attached to others. In the second year of training, I became a speaking co-leader. I was paired with a licensed clinician and a process observer. I found that my relationships with group members developed differently depending on the person.

I had concerns about my competence to provide a useful service to the group members. As a result, I pushed myself to offer the group members something that would be helpful. Through supervision I became aware of how my own characteristic ways of thinking about people influenced my interactions with the group members. In supervision, we would often question our motives for making certain interventions or refraining from intervening. After questioning my own experiences, I began to wonder what the group members thought about me and therapists in general. What influence did I have on the participants? What did they think of me as compared to the licensed therapist? What did they think was helpful or not helpful? I continued to have questions after I finished with the training. I believe these questions led me to this dissertation.

My beliefs about being a group therapist. During my training as a group therapist I developed the belief that therapists had a significant influence on a group member's experience of therapy. Without a therapist that a group member can trust, I do not believe that a member can gain much from the group experience. Indeed, it can be very intimidating

to share in a group of people that may or may not want to hear what you have to say. Therapists have the responsibility for making group members feel safe.

Additionally, I found that therapists were able to offer a different perspective as compared to other group members. I believe that group therapists can provide group members insight into group member psychologies in a manner that sets them apart from the other group members. Admittedly, some group members can help other members develop insight. Yet, the combination of training and having a leadership role gives therapist the ability and freedom to help group members increase their understanding of themselves.

Personal motivation for this study. A personal motivation for examining the therapeutic relationship is my belief in the importance of relationships. I believe that humans are relationship seeking beings. As I see it, people develop characteristic ways of being in the world through their interactions with others in close relationships. The opportunity for change occurs when people are aware of themselves and their circumstances and they are able to choose a path consciously. I think that self-awareness can develop by being aware of how one's character interacts within relationships.

Group therapy is an attractive treatment approach for me because I believe that group members can learn about themselves through an analysis of their relationships in group therapy. Group provides an interesting context in which people can see and analyze how they think about and relate to others *in vivo*. Group therapy can be an appropriate treatment model for many people. I also know that it can be an intimidating experience to speak in front of a group. Therapists can help group members make use of an intimidating group experience, but I wonder how group member perceive that help. Beyond promoting

therapeutic factors, I am interested in knowing what other ways group members perceive their relationships to their group therapists.

I value the perspectives that people have about their lives and their experiences. I respect how people understand themselves and the questioning that occurs when things no longer make sense. I am interested in how people perceive and make sense out of the world. In particular, I am very curious about how people understand themselves in relation to others. A phenomenological methodology that focuses on accessing a person's description of her experience fits with this interest in bearing witness to a person's experience.

Reactions during process. An interesting experience concerning the therapeutic relationship occurred during recruitment for the study and conducting interviews. When I started recruiting I decided that it would be appropriate to include participants with whom I had formerly been a therapist. If the opportunity arose, I decided that I would not screen these participants out. I wanted a mix of people that I had not been a therapist with, but I also thought that former group members would provide an interesting perspective. I had not been a group therapist for these people for several months and I thought that it would be relatively comfortable interacting with former group members in a new way.

Conversely, it was an odd experience to switch from being a former group therapist to being a researcher studying relationships with group therapists. I was hyper-aware of not wanting my former relationship to negatively influence the interview experience. In some ways I believe that it was very helpful to have a former group therapist ask the participants about the therapeutic relationship. The experience of talking with me again highlighted the phenomenon in a very immediate way. However, when I asked what it was like to discuss the therapeutic relationship with a former therapist, the majority of the participants were

reserved in their responses. This was likely an intimidating question to be asked by a former therapist who was researching their experiences.

Several participants shared that they had participated in the study because of our former relationship. They spoke about a desire to reconnect after I finished as their therapist, albeit in a limited fashion. Their comments highlighted the experiences that many members had with losing group leaders. I am appreciative of all the participants and their contributions to this study. However, the act of participating in the research for my former group members impressed upon me the significance of the therapeutic relationship on a personal level.

As I entered into the data-analysis phase I became more aware of wanting to approach the data provided by my former group members with an awareness of my biases. Because of our former relationships, I was mindful that the former group members might not have felt comfortable offering me negative criticisms. I also wanted to be sure that my prior knowledge of them would not impinge upon my ability to analyze what they shared without undue bias. The process of reflecting on my own biases, prior experiences, and assumptions has been critical to the data-analysis. I believe it was rewarding to include former group members, but it also necessitated a hyperawareness of how previous experiences might color the data analysis.

I was very appreciative of having an auditor with whom I could share my ideas and frustrations. Through the process of thinking about the data and discussing it with another person, I became more comfortable with the data analysis. By the end of the analysis I was looking forward to discussing this information with more people. I also appreciated the opportunity to check in with the participants to hear their responses to my work. Although a

dissertation is often assumed to be an individual accomplishment, it has truly been a group process.

Descriptive statistics

The 10 participants were currently attending a process group offered at a university counseling center. There were six females and four males. The ages of the participants ranged from 21-31, with an average age of 24.3 ($SD = 2.83$). Five participants identified as being White, two as being Black, one as being biracial (White and Latina), one as being East-Asian, and one as being South-Asian. Six participants were undergraduates in either their junior or senior year of college. The other four were graduate students. Two were pursuing master's degrees and two pursuing doctoral degrees. Five of the participants were former group members of mine and five were not.

The participants came from four different process groups. Specific relationships between participants and group leaders (e.g., number of leaders) will be detailed in each participant's profile. The number of sessions of group therapy that participants attended ranged from 5 to 96 ($M = 41.4$, $SD = 28.69$). The number of sessions of group therapy that participants attended with their group therapists that they were seeing at the time of the interviews differed slightly with a range of 5 to 96 ($M = 35.8$, $SD = 30.53$). The majority of the participants had remained with the same group leader(s) ($n = 7$). Three participants had switched groups because of scheduling conflicts. Please refer to Table 1 for a summary of descriptive information concerning the sample.

Table 1.

Descriptive Statistics

<i>Summary of descriptive information for</i>	Gender	Age	Racial/ethnic identity	Total number of sessions attended

<i>the sample</i> (<i>N</i> = 10) Name				and (number of sessions with therapist at time of interview)
Dominique	Male	23	Black	30 (16)
Caroline	Female	21	East-Asian	60 (60)
Daria	Female	26	White	48 (10)
Ian	Male	31	White	18 (18)
Sophie	Female	25	Biracial (White/Latina)	55 (55)
Julia	Female	22	White	32 (32)
Roger	Male	24	White	5 (5)
Liz	Female	25	White	64 (60)
Fiona	Female	22	Black	96 (96)
Omer	Male	24	South-Asian	6 (6)

Participant profiles

To help preserve confidentiality, the participants chose pseudonyms to be referred to as in the text. The pseudonyms of the six female participants were Caroline, Daria, Sophie, Julia, Liz and Fiona. The pseudonyms of the four male participants were Dominique, Ian, Roger, and Omer. Furthermore, names were changed and identifying information altered in the transcriptions to bolster confidentiality. Profiles are provided for each participant with identifying information altered to ensure privacy (e.g., major and presenting problem). Five participants shared during the interview why they wanted to participate in the research study. This information is included within the descriptions of the participants.

Dominique. Dominique is a 23 year old African American male who is a junior majoring in the arts. At the time of the interview, Dominique had attended 16 sessions with his current group therapist and 14 group therapy sessions with another group therapist. He said that there was a single group therapist and no therapists in training in his groups. When Dominique first sought treatment, he was referred to group therapy to work on issues related to his mood. Dominique experienced mixed relationships with his group therapists. He

reported a safe and comforting relationship with his initial group therapy leader. He likened this relationship to a mother-son relationship. The group leader supported but did not force group members to pick one path over another.

He was ambivalent about his second group leader. One issue that he discussed multiple times was a feeling of vulnerability in the relationship. He described how he did not feel safe about sharing with the group leader because he was uncomfortable with how she interacted with him. Although Dominique was uncomfortable in his current relationship with his group leader, he made an effort to offer a polite critique of what he experienced. When asked about this Dominique said:

Dominique: I guess I don't know them as people. I know this is going to be documented, my goal isn't to discredit anybody, it's just my opinions, who am I? I don't want to feel like, you know, that I'm knocking anybody for this. I'm just saying what I think. Someone could interpret this way differently. I know with writing, things get interpreted way differently and I don't want to be that person to bash somebody's name.

Dominique felt like it was important to share the discomfort he experienced in the therapeutic relationship because it may be helpful for future group leaders to hear about.

Caroline. Caroline is a 21 year old East-Asian female who is a junior majoring in the arts. At the time of the interview, Caroline had attended 60 group therapy sessions, all with her current group therapist and multiple therapists in training. Caroline was referred from individual therapy to group therapy for issues related to self-esteem. Caroline talked about feeling very safe and attached to her leader. She experienced her leader as having a maternal

relationship with her, which meant a relationship that was supportive, yet willing to give difficult feedback. Caroline also valued the history that she had with her group leader.

Caroline: Therapist X is always the shining star. She has been the one that's always been there too, that kinda adds to it. The consistency.

Caroline described less secure relationships with the therapists in training. She reported valuing the licensed staff member more to the point that she might avoid going to group if the licensed therapist was not going to be present. She felt that she would have felt better about the therapists in training if they had been able to stay with the group for longer periods.

Daria. Daria is a 26 year old White female who is a graduate student on the MCV campus. At the time of the interview, Daria had attended 10 sessions with her current group therapists and 48 group therapy sessions overall. She had been in group therapy with multiple licensed therapists and therapists in training. Daria was referred to group therapy for issues related to her mood. Daria reported needing the leaders to ask her the right questions because she had difficulty saying what was most salient.

She also expressed the notion that knowing a professional was there to listen to her made group therapy a positive experience. Specifically, Daria appreciated that she was able to share upsetting emotions with her group leaders and that they would respect and listen to what she had to share.

Daria: Knowing that I have a good ear and a positive and welcoming person to receive that and to probe it and encourage it, brings it out and it's a good thing for me.

Ian. Ian is a 31 year old White male who is a graduate student in the allied health field. At the time of the interview, Ian had attended 18 group therapy sessions with the same

licensed staff member and several different therapists in training, one of which was the researcher. Ian was referred from individual therapy to group therapy for issues related to anxiety. Ian emphasized that the relationship with his leaders was one based on professionalism and safety. He described early experiences in group in which he felt vulnerable. When feeling vulnerable, group leaders checked in on him.

Ian: I think that it was, the primary licensed clinician in the room, she was very good about following up about how it felt for me to disclose my sexuality in front of the group. That was very thoughtful, comforting, very positive experience. This individual demonstrated great compassion and care. In Just a few words about “well how did it feel?”

He felt that the concern shown for him early in group by the leaders helped him gain a sense of trust and safety in group therapy. Ian also described his relationships with his leaders as being non-judgmental. From a non-judgmental relationship, Ian talked about feeling safe to explore his emotions openly with strangers.

Ian also shared that he wanted to participate in the study because he thought it was important for group leaders to receive feedback about their performance.

Ian: I think it is important for group leaders to know how they are doing and how they are perceived. I wanted to take the opportunity to let the counseling services know that they are doing a great job. I haven’t found it weird to talk with you and not to share. I am not getting anything out of this. It is altruistic, I haven’t held back. It is important to do because the leaders are doing a great job.

Sophie. Sophie is a 25 year old Biracial female (Latina and White) senior who is majoring in the humanities. At the time of the interview, Sophie had attended 55 sessions of

group therapy with the same licensed staff member and several different therapists in training, one of which was the researcher. Sophie was referred to group therapy for issues related to her mood. Sophie described being very close to one of her leaders that had been present over the course of her treatment. She articulated that the sense of history helped her rely on her leader to remember important aspects of her life that she might not even remember.

As mentioned above, Sophie was a group member in one of the groups that I co-lead at the university counseling services. During the interview she primarily focused on talking about her current therapeutic relationships. However, she shared that she was willing to participate in the study because of our former therapeutic relationship.

Sophie: I liked that you were there because you had a sense of history. I liked having the chance to talk about group therapy with someone who is familiar with it. That is why I was eager to participate.

She felt safe to share her experience of therapeutic relationships with a former therapist. In general, she was appreciative of what therapists offered to group members.

Sophie: I know that it's their job, but it's something that you devote a lot of your energy to. Not just job energy, but probably emotional energy too, and I recognize that, that it might be a difficult job at times. I feel grateful that she (current therapist) would come forward and want to do this every week... That makes me feel mostly grateful more than anything else.

Julia. Julia is a 22 year old White female senior who is majoring in education. At the time of the interview, Julia had attended 22 sessions of group therapy with the same licensed staff member and several different therapists in training, one of which was the

researcher. Julia was referred to group therapy for issues related to her mood. Julia described a strong feeling of trust with the leader that she has had throughout her group therapy experience.

Julia: I have been in therapy before, not group therapy but one on one. It takes some time for me to trust the therapist. I've had some therapists in the past that I just couldn't talk to. But I feel like I can talk to Therapist X. Like she is very open and receptive to information and what I have to say. So...that comforts me and I feel like she actually cares about what's going on.

She also noted that her therapist helped her feel comfortable in group when she first started group therapy by including her in the group discussion. Julia described having been in therapy for much of her life and how she noticed that like most therapists, she had a somewhat distant relationship with her group therapist. She reported feeling closer to other group members because she knew more about them as compared to the group therapists. Nonetheless, she valued the distance and remarked that she would be concerned if the therapists disclosed more personal information.

Roger. Roger is a 24 year old White male graduate student in an allied health field. At the time of the interview, Roger had attended 5 sessions of group therapy. Roger was referred to group therapy for issues related to anxiety. Out of all the participants, Roger had attended the fewest group sessions. Though not having much time to develop relationships with his co-leaders, he had experienced their relationships in three distinct ways.

Roger: They are supportive, encouraging, challenging. Those are some of the main adjectives that come to mind.

Initially he described how the leaders had encouraged him to share his story and how they had supported him when he doubted that his concerns were worth sharing. He was more intimidated by being challenged by the leaders to analyze why he thinks what he thinks, but he also valued this aspect of their relationship.

Roger was also a keen observer of the differences between the licensed staff members and leaders in training. He noticed that the therapist in training was often “stirred” more deeply by distressing things shared in group as compared to the licensed therapist. Roger often sympathized with the therapist in training because he had similar experiences in his own healthcare training.

Liz. Liz is a 25 year old White female senior who is majoring in the humanities. At the time of the interview, Liz had attended 60 sessions of group therapy with the same licensed staff member and several different therapists in training, one of which was the researcher. Liz was referred to group therapy for issues related to anxiety. Liz shared ambivalence about the boundaries that the group leaders establish for group members. At times, she saw these boundaries as helping her experience of group but at other times damaging it.

Liz: It’s sometimes hard to tell what your real relationship is with a therapist because there is professional caring. It is a weird job because you are empathetic but you also distance yourself. It is hard to tell the boundary, to figure out the nature of the relationship, to figure out the rules are in the interpersonal relationship.

While recognizing the importance of setting limits, she also desired for the leaders to offer her more help if she needed it at the time. For Liz, it was very important to feel like her

leaders were caring and trustworthy. She had experienced several group leaders as too distant and unhelpful when someone was in crisis in the group.

Fiona. Fiona is a 22 year old African American female senior who is majoring in the arts. At the time of the interview, Fiona had attended 96 sessions of group therapy with the same licensed staff member and several different therapists in training, one of which was the researcher. Fiona was referred to group therapy for issues related interpersonal difficulties. Fiona talked about how it was very difficult for her to have therapists come and go. She was often unable to say good-bye to therapists because she had to miss the end of the semester sessions used to say good-bye. Fiona shared that it was hard not to have a chance to say good-bye therapists in training, one of which was me.

She described her leaders as people that she could trust to share private information because she did not know anything about their personal lives. She valued the anonymity of the leadership team because that is something that she does not have if she speaks with friends and family. Although valuing the boundaries, she also experienced the relationships as awkward, especially if she runs into leaders in public.

Fiona: After having spilled my guts and told all this stuff about me its weird that I can't... that there are boundaries that have to be maintained. Like if I see one of my leaders on the street I can't be like "Hi How are you!" I don't feel comfortable doing that, I just do a polite wave and keep going. It's hard for me because I'm super social and outgoing to just say "oh hi..." they know everything about me. But I just keep going.

Omer. Omer is a 24 year old South-Asian male graduate student in an allied health field. At the time of the interview, Omer had attended 6 sessions of group therapy. Omer

was referred to group therapy for issues related to anxiety. Like Roger, Omer was relatively new to group therapy at the time of the interview. Omer talked about how he was still getting used to group and that he was often unsure of why group therapists focused on topics he did not find important.

Omer: Yeah, every once in awhile we'll end up kinda stuck. We'll talk about a mundane issue that I don't think is at the heart of what might be upsetting someone or might be a big issue at all...but they (the group leaders) just kept talking about and talking about it. I was just like, "can we please move on?"

He valued the leaders' presence, but he wished that they would focus on "deeper" issues more often in therapy. Drawing on this experience, he described how he made it his own responsibility to talk about "deeper" topics instead of letting the group focus on mundane topics. Despite questioning the group leaders' intentions at times, he indicated that he felt safe with the therapists and that they were offering a helpful treatment.

Description of findings

The findings from the qualitative data analysis yielded eight categories of how group members perceive therapeutic relationships. The eight categories emerged out of responses to the two guiding research questions.

1. How do clients perceive their relationships with their group co-leaders?
2. How do the therapeutic relationships influence the clients' experience of group?

Each category of experience includes either descriptions of client perceptions of the therapeutic relationships and/or how the relationships influenced their experience of group therapy. Each of the categories consists of one or more related themes. The categories and

associated themes are summarized in Table 2. Descriptions of the experiences are offered according to the data analytic plan. For each of the themes, I recorded textural descriptions by employing the words of the participants. Structural descriptions are added to the description of the findings when applicable. When present, the structural descriptions help highlight the context in which the theme arises. Essence descriptions are offered for each theme in order to provide a summary statement which records the essence of the phenomenon under discussion.

Table 2.

Summary of Categories and Themes

Category	Theme	Description
Presence of group leaders	Consistent leadership	Group members relied upon having a therapist that was consistently present.
	Loss of a leader	The loss of a leader was a sad and difficult experience
	New leader	It took time for group members to get comfortable with new leaders.
Safety	Trust	Group members needed to trust their therapists in order to participate in group
	Judgment	An absence of judgment by therapists helped group members feel comfortable in group.
Caring	Caring	Therapists cared about the group members.
Sharing	Listened To	Therapists listened to what group members shared. This encouraged further sharing
	Openness	Therapists were open to whatever group members wanted to share.
	Right Questions	Therapists asked questions

		that helped group members share what they needed to.
Running Group	Facilitation	Therapists facilitated the group by highlighting themes and helping members work together.
	Encouraging Responsibility	Therapists let the members know it was their responsibility to do their own work in group.
Levels of Leadership	Expertise	Group members were impressed with the skill and expertise of the therapists.
	Therapists in Training	Therapists in training had fewer skills than licensed leaders. Group members were ambivalent about their presence.
	Multiple Therapists	Having multiple therapists work together helped create new perspectives on the group and its members.
Developing Understanding	Challenges	Therapists challenged members to analyze uncomfortable aspects of themselves.
	Connections	Therapists help group members make connections and develop new ideas about patterns and themes.
Intimacy with Boundaries	Intimacy with Boundaries	Group members felt very close to their therapist but they also noticed distinct boundaries. Intimacy with boundaries was an uncommon and awkward experience.

Presence of group leaders. The participants described the alternating presence and absence of group leaders as an important dimension of their therapeutic relationships. This category of experience divides into three themes including consistent leadership, gaining a new leader, and losing a leader.

Consistent leadership as an aspect of the therapeutic relationship. The group members described the importance of having a close attachment to at least one group leader who was consistently present for the sessions. This was often a therapist that group members met during one of their first group sessions and who had continued to be their therapist for the duration of their treatment. A quote from Sophie describes this relationship dimension:

Sophie: A sense of permanence too because Therapist X is always there. Every single time. People might be sick, they might come and go and different leaders will come and go, but Therapist X is always there. That makes me feel good that somebody is following the thread of the group the entire time.

In addition to having someone follow the “thread of the group,” consistent group leaders fulfilled other functions for group members. Several group members described consistent leaders as being a support that they could trust in. Sophie called her consistent therapist her “anchor” and Caroline called hers a “rock.” These participants relied on the consistency of their leader during tumultuous times. Participants also described the consistent leaders as performing an important history taking function. Several group members shared how they were impressed that the therapists would remember members after semester absences or even remember important information that the group members had once spoken but had forgotten.

The influence of consistent leadership on one’s experience of group. The consistent leader’s ability to remember a person’s history promoted comfort because group members could trust that the leaders had a comprehensive view of their difficulties. Sophie described her appreciation that consistent therapists had a comprehensive view of group members.

Sophie: I think a lot of people are concerned about being viewed as one dimensional...I always want to portray myself in a way that doesn't lead people to believe that I am just this one pigeon-holed thing. I think that having the group leaders there, it makes it...there is some other kind of past idea of what happened in the past. Therapist X will bring up other events that have happened before others in the room who had not been there before. I like that she remembers those things. She really keeps up on that.

Though the presence of a consistent therapist was highly appreciated, the absence of one was a bitter experience. Participants expressed concerns about when a consistent therapist was absent from a therapy session. Caroline shared her distress in the following quote.

Caroline: When Therapist X is on vacation I always feel like, oh God, what's it going to be? Are we just going to sit there and not get anything done or are we going to be productive and really delve deep into things?

She recognized work could occur, but having a consistent leader allayed concerns about whether the group session would be helpful.

Multiple group members also found that having a consistent leader helped them bear the loss of another leader to whom they were attached. For instance, Fiona talked about how she was often sad and hurt by therapists leaving. She found that it was "comforting to have a consistent leader" in the face of the loss.

Essence of a consistent leader. Consistent leaders were therapists that the group members could trust would be present for group sessions week in and week out. The group members relied on their consistency as a support, especially in the face of a loss of another

leader. They counted on them to maintain a perspective informed by history. Their absence was sorely missed by the group members. A consistent leader was someone who was ever-present in the group and waiting when a member returned from an absence.

The influence of having a new leader on one's experience of group. New therapists did not offer the same broad and rounded perspective of a consistent therapist because of a lack of history. Julia noted that she worried that her new leaders would misunderstand her because they did not know her whole story. Because new therapists might misunderstand them, group members experienced discomfort when entering into these relationships. One aspect of the discomfort was related to having to tell one's story over again. Fiona shares her discomfort with interacting with a new leader.

Fiona: It's hard to start another semester and you are looking at different group leaders and they don't know, as far as I know, they don't know all my junk. It's that weirdness all over again because there is a new person you have to tell your whole life story to. That's uncomfortable.

Multiple participants talked about how the process of self-disclosing to a new therapist felt awkward because much of what was shared had already been said to everyone else in the room. Sophie reported that she had to explain more of the context of her problems instead of focusing on the specifics of her current concerns in order to help the new therapist "catch up." Having a new leader altered group member comfort in group and it could alter what they talked about in group.

The process of becoming comfortable in the relationships took time. Julia describes the caution members experienced when forming new relationships with group therapists.

Julia: I obviously haven't built the history with her, like with Therapist X. It is a getting used to factor. She has good questions and insights. She's just new. I have to build a relationship with her...I just have to take the time to get comfortable with having them there.

It appears that once a therapeutic relationship is no longer new a sense of comfort develops. This is likely an expression of group members seeing the new therapists as becoming consistent therapists.

Essence of having a new leader. Group members were often ambivalent about entering a relationship with a new therapist. The experience of having a new therapist often occurred for returning members who either had to transition to another group or when there was a new therapist in training at the start of an academic year. This new relationship forced the group members to alter how they typically interacted in group. They felt compelled to share more of their history and less of their current difficulties. This process was often uncomfortable. Comfort rose once a history developed between members and new therapists.

The influence of losing a leader on one's experience of group. Group members lamented the loss of group leaders because they had become comfortable interacting with the therapists. The following quotes represent affective responses to experiencing the loss of leaders.

Caroline: Yeah, some co-leaders come and go and are only there for a year. It's upsetting.

Sophie: You also, I thought you were always very, I was actually sad when you left because I always thought that you always brought up a lot of good subjects.

Fiona: I have terrible issues with people dying and separating. I feel sad when people leave. I am hurt.

The participants found that the group changed following the loss of a leader. Certain attributes that a group therapist typically provided would immediately be absent from the group discussion. For instance, Caroline found that when one leader left, the leader's skill of providing interesting insights were lost. Sophie worried that part of her story could not be recovered. The group itself also acted differently with members being less open. Caroline shared this quote about her experience of how the group changed following the loss of a leader.

Caroline: It was kinda like quiet at first, it took a while to get the ball rolling.

Essence of losing a leader. The loss of a therapist could be a difficult experience for group members. Therapists often left groups at the end of training experiences in group therapy offered at the counseling center. Group members felt sad about the loss, especially when they had a close attachment to the leader. Group members missed what the therapists offered to the group in terms of their skills and clinical focus. Others were concerned about losing a person in the group who had an in depth knowledge of them.

Caring. An important aspect of the therapeutic relationship that group members described was the sense of caring they experienced during their interactions with their group leaders. Group members felt as though the leaders cared about their lives and their struggles. Some group members found this caring as being similar to having a mother offer care.

Description of caring as an aspect of the therapeutic relationship. Group members felt that therapists offered care. Roger and Caroline described the care as providing a sense of warmth and deep connection, despite the boundaries of a professional relationship.

Several group members experienced care through extra help that group therapists offered. In particular, Liz was once going through a crisis. She worried about going to her therapists for help outside of a group session. She was concerned because one of the group agreements was that therapeutic work should occur within the group. However, Liz decided to see her therapist because she could not wait.

Liz: One group leader I did talk to her individually when I was in crisis. She was really helpful. That let me know that she cared. She said some things that really helped me.

The leader made an exception to the group agreement when Liz felt that it was needed and this led to her experience of feeling cared for by the therapist.

Some members found that the therapists cared for them as their mothers did. For Dominique, motherly care was shown through compassion offered to group members as mothers offer compassion to their children. Caroline's group therapist acted like her mother when Caroline would talk about difficult issues.

Caroline: When she cried when I broke up with my boyfriend, she knew how upsetting it was for me and for her to feel that too, because she knows so much about me in this relationship. Things like I pretty much would only tell me mom. And mom cried when I told her that sort of thing. The basic reactions to our interactions. Her instinctual reaction, she felt sad. Other people just have this caring feeling, just safe. It reminds me a lot of my mom, I guess is like the only thing. She cries and she gives me really good advice just like my mom. I can hear her caring in the words she tells me. Whereas like I can hug my mom but I can't hug co-leaders. I can feel the love and caring that's there.

It is interesting to note that Caroline draws a distinction between her mother's care and care *as if* it was offered by her mom. She recognized that there were limits to the caring (e.g., no hugging) but that the therapists could still provide a deep sense of caring to the members.

Essence of caring in the therapeutic relationship. Group members appreciated that their therapists cared about their concerns and what was happening in their lives. Rather than being told that they cared, group therapists showed their care to the group members. Care was shown by expressions of compassion and sympathy. It was also shown outside the context of therapy when the therapists would meet with the clients to give them extra support. Some members found that the leaders interacted with them in a way that showed motherly care.

Safety. Feeling safe in the therapeutic relationship was an important dimension of the therapeutic relationship for the group members. The safety category contains two themes: trust and judgment. When safe, group members felt like they were able to participate fully in the group. Without safety, group members were too afraid to work in group. Comfort was often present with safety, but safety also made it possible for group members to face discomfort.

Trust as an aspect of the therapeutic relationship. Participants talked about the importance of trusting their therapists because of the vulnerability they felt about sharing their stories in a group. Ian described the interplay between vulnerability and trust.

Ian: There's definitely vulnerability. I see it, I feel vulnerable. I view the relationship as a professional one in which I trust this caregiver to provide professional care. The only way that I can move forward and talk about the things that I need to talk about in therapy is by reminding myself that these individuals are not friends that I am talking

to over drinks or whatever. Or a partner, a life partner in the bedroom as we fall asleep. This is a professional relationship and what I say they hear what others wouldn't hear. There's definitely a certain degree of trust that goes with submitting to this sort of interaction.

An important aspect of trust in the relationship was that group leaders were able to offer a safe environment in which group members could share personal stories. Roger reported how he was concerned about coming out to his group. However, he was able to share this information because of his trust in his relationship with his group therapists.

Roger: It feels safe to share in there, where if someone had a homophobic reaction, then I feel like it would be on them to own up to whatever that was about. Whereas, in real life, that could create a hostile work or school environment. That works in more than just sexuality, that works in a lot of areas.

He was able to trust that the group leaders would hold people accountable if they had a reaction that made him feel unsafe.

Another aspect of trust that several group members emphasized was that therapists offered an effective professional service. Omer shared the following statement about trusting the services provided.

Omer: There is trust, basically. I feel like there is. I feel like they are there to help, that they know what they are doing, and know how to do it.

The influence of trust on one's experience of group. Multiple participants talked about how trust developed in the relationship when group leaders emphasized accountability in the groups. Daria described how it was helpful for group therapists to "reiterate the

protocols,” referring to the rules followed in group. Protocols were reiterated each time a new group member attended a session.

A special case of developing trust occurred when group members transitioned into a group. This was a period of time in which group members often felt unsafe about participating in group, whether they were transferring from individual, from group therapy, or from an intake session. Group members identified therapists as making the transition from individual to group therapy comfortable because of the trusting and safe relationship they offered. Julia provided the following summary of her experience of transitioning to group.

Julia: I would say that the relationship I have with Therapist X has made the transition from individual therapy to group therapy fairly easy. When I first went to the counseling center and the lady I saw recommended group therapy I was really like “oh I don’t know if I can share my personal life with like twelve other people.” I just don’t understand how I can do this. Then I went to the first meeting and I sat there and I listened and I was like, “wow people do like tell their deep dark secrets to like random strangers.” I found it an interesting concept. At the end, Therapist X checked in with me and asked me how I was doing and I found that very comforting, because it would have been very easy for her to end the session. But that way she included me and she let me have some input. I thought it was nice that she checked back in with the new person. She made sure I wasn’t feeling lost and overwhelmed.

By checking in with Julia, her therapist helped her feel comfortable in the group therapy setting. Out of this interaction, she described how she was able to trust that the therapist was there to help her and make group safe.

Trust decreased when group members experienced a loss of safety in the group. For instance, Liz described a situation in which she was concerned that another group member was suicidal. She felt that the group leaders did not try to help this person handle the crisis. She offered the following reaction to the situation.

Liz: They completely ignored it. That made me feel like “well gosh, what’s the point of coming?” If I had something really bad they would probably ignore me too.

Liz was so distraught by this experience that she stopped going to that particular group.

Dominique also questioned whether he could continue with group because of a lack of trust with a therapist. He described not feeling safe in how his group leader interacted with him.

Dominique: It seems like she’s trying to evoke emotion out of everybody. I have never been to therapy prior to this so my view of therapy was that you go there and you work out your problems at your own pace. It seems this time she’s trying to get them out of you almost. They want to see like emotions, like tears like yelling, not in a violent way but to get that emotion out of you. It seems this was more like to force the emotion out of you.

Dominique went on to describe how this style of interaction felt intrusive to him. He felt that he could not open himself up to the group at a pace that felt safe. The lack of safety went beyond a sense of discomfort with the situation. Without interactions that promoted safety or a felt sense of trust, group members would often disengage from treatment.

Essence of trust in the therapeutic relationship. Trusting therapists is a fundamental component to a group member’s experience of therapy. Group members feel vulnerable when sharing but trusting a therapist helps buffer against it. For some members, trust

develops through therapists checking in on how they are doing and by seeing the therapists behave professionally. Trust may dissipate if group members feel like the therapists are not helping enough or are pressuring group members too much. It is important to group members to develop a sense of trust with their therapists early on in their group treatment.

Judgment as an aspect of the therapeutic relationship. Judgment was the second theme that fit within the category of safety. Specifically, group members experienced varying levels of judgment from group therapists and this influenced their sense of safety in the relationship. Sophie and Ian both shared how having a group therapist that was non-judgmental fit their expectations of therapeutic relationships. Several participants found that they were able to share more personal information when they did not fear judgment from group leaders. Liz described her experience with judgment.

Liz: The therapists make me feel like I could say most things. They wouldn't judge me. They might say well "that is weird," well they wouldn't say that. They would ask what makes me feel that way. They wouldn't say "you're bad and get out of our therapy session."

Multiple participants relied on the belief that the therapists were nonjudgmental in order to be comfortable with sharing shameful experiences.

In contrast to experiences of non-judgment, Dominique lost his sense of safety in the relationship when he did feel judged by a group leader. When asked to describe a memorable experience with his group leader he shared that she had once asked him "what again are you here for?" after he had been in group for several weeks. Dominique shared the following reactions to being asked this question.

Dominique: I don't know if she was saying if my problem wasn't as severe as everyone else or if I even had a problem, I felt kinda funny about that question. Dominique then shared how his group leader knew his presenting problem and that the question seemed to harbor a judgment she had about him being in her group.

Participants described group therapists engaging in specific behaviors and avoiding other behaviors that showed whether they were judgmental or not. For instance, Liz said that leaders would "never criticize" her for what she had shared. Sophie knew that her leader was not judging because she could tell she was there simply "to listen." In contrast, Dominique perceived his therapist's question as a criticism of his presence in group.

The influence of judgment on one's experience of group. Group members did not describe in depth how therapist judgment influenced their experience of group. Several members looked forward to group because they wanted a relationship in which they would not be judged. In an absence of judgment, other members felt safe enough to share anything in the group. When talking about having group leaders that were non-judgmental, Ian shared the following statement.

Ian: It is very much appreciated because it makes the client that much more willing to share.

Essence of judgment in the therapeutic relationship. Group members relied on therapists being non-judgmental. Believing that a therapist was not judging allowed group members to feel safe enough to share. In contrast, judgment made group members feel less safe with sharing their experiences with the group. Perceiving a lack of judgment occurred when group members witnessed therapists who listened but did not criticize. A perception of

judgment occurred when therapists criticized clients about what they were saying or doing in group.

Sharing. Group members found that through their trusting and caring relationships with group leaders, they were able to share private information. The experience of sharing was split along three themes. First, group members felt that group leaders were open to sharing. Second, they had the experience of being listened to by group leaders. Third, group leaders also were able to ask the right questions to assist with disclosing. The combination of these experiences led group members towards feeling like they were able to disclose private information openly.

Openness as an aspect of the therapeutic relationship. Openness was characterized as not feeling pushed to do or say a specific thing, but rather knowing that the leaders were open to hearing whatever the group members shared. This theme is similar to how some group members described the group therapists being non-judgmental. The openness theme differs from judgment, in that it conveys a sense of interest and openness to sharing as opposed to relief that one is not being judged when sharing.

Group members described a sense of openness when their leaders let them know that they were interested in their stories and open to hearing what they had to say. In response to this, Liz indicated that she felt as if she “could share anything.” Similarly, Daria said, “I’ve felt encouraged to share.” Fiona described her response to having therapists show an interest in what she had to say.

Fiona: I feel like a lot of people come into group and they are really weary of being in front of these people that they don’t know and having to tell all this personal stuff.

But I feel like the way that I've experienced group probably because of my leaders, is that it's not such a big deal to share.

With her therapists helping her not worry about sharing, Fiona remarked how she was able to reveal more personal information to the group as compared to her family and friends.

Openness was also conveyed on a group wide level. Roger talked about how the therapists helped create "open interactions" in the group. For Roger, this meant that therapists encouraged group members to be open to work with each other and to hear each other's concerns. He described how the therapists were present to ensure that the group discussions would be accepting of what people had to contribute.

The influence of openness on one's experience of group. Group member engagement with the group-as-a-whole varied depending on their experience of group leader openness. When group members felt as if leaders were open to sharing, group members would interact with the group more. They felt comfortable in their interactions with group leaders and group members. However, when members experienced leaders as not being open to what or how they shared, they felt less open to sharing with the whole group. Dominique had recently transferred to another group and he recalled how he had been more open with his previous leader because of the "compassion" she showed to him and other group members. In contrast, Dominique described his reaction to having his therapist comment on how he makes jokes in group.

Dominique: Yeah I guess in the spring I would just talk freely but this one I don't know it seems more so like...I don't, I mean I still make, I kinda make jokes sometimes but not as much. I don't if its because less people, but I think the tone is a little more, not as, like once again back to that comfort thing, the tone isn't the same,

I'm more cautious of like, I wouldn't make any offensive jokes but I would kinda just, if I'm telling a story about my life I would add some humor to it for comic relief, but I don't do it as much now because it seems as if like humor not saying that she's not a humorous person, but she says, "that clouds the truth of the story you are telling," she just wants you to just say factually exactly how it happened.

Dominique went on to state that he was less open in group because he felt as though his mode of sharing (i.e., using humor) was not welcomed by his group leader. It is clear from Dominique's experience that a perceived lack of openness relates to feelings of criticism and judgment.

Essence of openness in the therapeutic relationship. Group members described a sense that their leaders were open to whatever they needed to share. The relationship with the group therapists helped make it possible to share anything in front of a group of relative strangers. An absence of openness reduced a person's comfort to share. Therapists showed their level of openness by encouraging disclosure and not reacting with bias towards what and how people disclosed in the group.

Listened to as an aspect of the therapeutic relationship. Being listened to builds on the experience of therapist openness. Not only were leaders open to what group members were saying, they paid attention to what was said. Roger found that a sense of support developed out of the experience of being heard.

Roger: They are very attentive to everything going on in the group and different people's actions. More of an attention and presence, that's the main supportive factor overall.

Group members felt like the therapists paid attention to what everyone had to say and they did not avoid listening to stories that might be difficult to hear. Daria shared how she appreciated being listened to when sharing difficult emotions.

Daria: A couple of times this has happened. I've shared something and it was particularly difficult for me to talk about and I got really emotional and the group leader acknowledged my emotion and appreciated my emotion. That felt good to be, to have that appreciation shown, that I had expressed that emotion. She just was really appreciative that I was able to share that and encouraged me to continue with other explorations like that. It just was a good thing to know that I was listened to. In this quote, Daria expressed how the experience of being listened to encouraged her to share. She recognized that the therapists had heard what she shared because they acknowledged what she was feeling.

Sophie had similar observations about being listened to by group therapists. During the initial interview Sophie talked about how having a therapist that listens, leads to sharing important information.

Sophie: I feel like being close to Therapist X helps not only me but a lot of people in the group. Because a lot of people, when a problem arises, they will look at Therapist X and pay attention to her. They are looking for validation from her that she is listening and that she is paying attention. I find that interesting. I think that can prompt people to say something that they wouldn't normally because they might feel that they wouldn't be listened to by anyone else in the group. Sophie continues with her description of being listened to.

Sophie: It also makes it easier to share something that might be hard to share, even if that was after I felt like I was accepted into the group. I've experienced many cycles of revealing things to the group, and each time the attentive listening of the group leaders helped me share.

For Sophie being listened to creates an atmosphere in which group members feel comfortable with disclosing information that they typically would not share. It is also a process that develops over time; with more experiences of being listened to, group members will feel comfortable with sharing.

Group members knew that they were listened to by group therapists through verbal and non-verbal communication. In terms of verbal recognition, Sophie found that when leaders responded to what she shared, their statements showed that they understood what she said. Daria knew that she had been listened to because the leaders voiced the emotions she was trying to describe.

The majority of participants experienced being listened to non-verbally. Roger reported that his leader “sits up very straight.” Ian found that his therapists’ “body language is extremely reassuring. I notice that as we are sharing they are watching us.” Sophie related that, “Her movements are always very calm. She sits and she is obviously attentive. That always makes me feel better.” Non-verbal communication through calmly sitting still and positioning the body toward the person speaking showed that the therapists were listening.

The influence of being listened to on one's experience of group. A positive perception of attending group therapy grew out of the experience of being listened to. Daria shared that she “felt good about going to group” as a result of knowing that her therapists listened to her difficulties. Julia found that being heard made her feel more comfortable in

the large group; she shared how she felt “special” because the therapist could focus on an individual within the group. Ian found that the attentive body language had an effect on the group as a whole.

Ian: It induces interaction and fosters that sort of sharing and caring supportive environment.

Additionally, Ian shared that the constant focus of the group therapists was “contagious” in that it reminded group members to stay focused and continue to work in group.

Essence of being listened to. Being listened to leads to experiences of being supported and encouraged to share more. Group members appreciated that their therapists listened to what they shared. Being listened to encouraged people to come to group and participate. Therapists would show they listened by voicing what had been shared. They also showed they listened by positioning their body in a way that displayed their focus on the person speaking.

Right questions as an aspect of the therapeutic relationship. Group members found that therapists were able to ask questions that helped them share more important information. The group leaders had an expertise in asking questions that helped members open their minds to new perspectives about difficulties they were experiencing. Daria felt that having group therapists ask the right questions was a special experience for her in the group.

Daria: Particularly for me, its how I need to be talked to. Sometimes I’m not able to communicate the things I want to. So I need somebody to ask the right questions or put a different spin on it for me so that I can express it. So for me personally that’s important to be able to ask the right questions.

Through questioning, Daria was able to divulge information that otherwise would have been difficult for her to share or even be aware that it needed to be shared. Fiona had a similar experience with the questioning.

Fiona: They help me come to awesome realizations just by the prompting questions that they ask. I really think about it.

The questioning provided a way for the group members to think about their issues in new ways and with greater depth.

The influence of right questions on one's experience of group. Group members talked about the experience of being asked the right question within the context of the therapeutic relationship. However, they had limited information to share on how this influenced their experience of group as a whole. Omer found that the group was able to delve into “deeper” conversations about issues presented when they responded to the questioning of the therapists. Without the questioning, he felt like the issues would have been “skimmed over” by the group. At a more basic level, Caroline could not conceive of a group without therapists asking questions.

Caroline: I feel like if they weren't there being leaders and kind of just asking the right questions then it wouldn't be anything. It would be kinda just like a bunch of people hanging out in a room for an hour and a half. So I feel like the group leaders really make it group therapy.

Essence of being asked the right questions. When therapists asked the right questions they helped group members share important information. Being asked the right questions assisted participants to share pertinent and helpful information. Being asked the right questions also led to group members thinking in new ways about what they were

sharing. Asking the right questions helped the group members look at issues on a deeper level. Finally, being asked the right questions is considered a quintessential experience of group therapy. Without therapists asking questions, it would no longer be group therapy.

Running the group. Group members described their therapists as running the group. There were two themes for this category: facilitating the group and encouraging responsibility. Facilitation provided a structure within which the group members could interact meaningfully with each other. Encouraging responsibility helped the group members realize that it was their duty to work in therapy.

Facilitation as an aspect of the therapeutic relationship. Group members described the group therapists as facilitating the group. For several group members, facilitation was experienced as a balance between group therapists intervening and letting group members interact on their own. Julia provided the term facilitate to describe this theme.

Interviewer: Any thoughts on the nature of that role, being that facilitator?

Julia: It's good. It really helps the group therapy aspect of it. If they were more involved in the group it would become more like individual therapy in a group. This way they pose questions, but they also pose other groups members to pose questions. A lot of the therapy I get is from other group members asking questions and giving insight from their life into my situation. So they are kinda facilitators in that they are not super active, a lot of my therapy does come from the 12 people sitting there.

This quote highlights an important aspect of facilitation in that the group therapists help group members work together. Similarly, Roger described the facilitation process as group therapists encouraging “feedback from other people to get the group wheels spinning.”

Facilitation also provided structure within which the group members could share their concerns comfortably. For instance, Sophie talked about how she once worried she would share her stories “too fast or frantically.” However, her therapists helped her keep calm by having her pace herself with her self-disclosure.

It is interesting to note that the group members had positive and negative reactions to the facilitation. On the positive side, group therapists helped move conversations to new areas and to engage group members who might otherwise stay silent. Ian remarked, “The therapists do a wonderful job of keeping those themes running and inducing some of the clients to talk about things that they may not otherwise talk about.” Similarly, Roger appreciated that the group leaders, “keep people, I don’t want to say on task, but they keep them engaged.” Caroline appreciated that the group leaders “kept” the group together.

In contrast, the facilitation of the group by therapists could be seen as negative at times. Omer shared that the group leaders once focused on a topic that did not seem to have much relevance to the group as a whole. He offered the following reaction.

Omer: It is frustrating, but maybe I don’t see something there that they do. I defer to them because this isn’t my field. Maybe there is something important there that I’m thinking isn’t as important. But I didn’t see anything come out of it.

Dominique appreciated that one of his group leaders gave everyone an “equal chance to speak.” However, he disliked how his current group therapist let the group run like a “free for all.” Overall, several participants criticized therapist facilitation when therapists failed to direct the group in a way that led the group to discuss topics that were important to them personally.

Group leaders facilitated the group verbally and nonverbally. In terms of verbal facilitation, group leaders directed members to talk about their impressions of each other. Sophie appreciated this experience as can be seen in the following quote.

Sophie: I like that they'll direct to me what I am feeling right now about another group member.

Roger said that they also facilitated the group by verbally "integrating people's histories together." Through this integration, the group members were able to continue with their discussions. In terms of non-verbal facilitation, Ian noted that poignant looks towards people who might have issues related to someone speaking would also foster communication.

The influence of facilitation on one's experience of group. Group members counted on the group therapists to facilitate the group process. Without leaders facilitating, Caroline noted that "group would just be useless." Directing group members to work together had a significant influence on the participants' experience of group. By encouraging interaction among group members, Ian found that the group therapists kept the group from feeling stagnant and stymied. Encouraging interaction also led group members to appreciate that they were in a therapy setting in which they could receive help from therapists and clients. Fiona shared her own appreciation of this dynamic.

Fiona: So I like that they'll direct to me what I am feeling right now about another group member. I don't know the word to use...they make connections between other people because that always helps me. One person could be totally different but we have something in common and that person and I are able to help each other.

Although the group members appreciated the interventions the therapists made to structure the group, Julia noted that there should be a limit to their interaction.

Julia: If they were more involved in the group it would become more like individual therapy in a group.

The therapists have to balance between intervening enough to help the clients work together and not intervening too much because it would decrease the client-client interactions.

Another aspect of facilitation that helped differentiate group therapy from individual therapy was how the leaders helped the group members work together. Fiona offered her perspective on this phenomenon.

For me with the way that the leaders find ways to thread everyone together, it makes it, actually make sense for me to be in group. Because if I were just there in a group but none of us ever interacted I would think I could do this by myself.

Essence of facilitation. Through facilitation, therapists help group members work together to help each other. Facilitation consists of directing members to share with each other. It can be conducted by asking clients to talk with each other, integrate stories together, or by giving a knowing glance to someone who would benefit from interacting at a particular moment. Therapists facilitate by connecting group members to each other; they also refrain from focusing too much on one person. Facilitation sets group therapy apart from individual therapy. Group members not only receive attention from therapists, but they also benefit from interactions with group members. This is made possible through facilitation.

Encouraging responsibility as an aspect of the therapeutic relationship. For as much as group leaders helped the group members work together, they also inspired them to do their own work. Members appreciated that leaders made it apparent that it was their responsibility to share their concerns in the group. Omer recalled that his group therapists said, “It is your responsibility to talk about the issue that you want to talk about.” Ian found

that having therapists encourage him to do his own work and to make his own decisions promoted a sense of taking control over his treatment.

Ian: At first I was worried the therapists would, we would present an issue and they would say “this is what you should do.” It has never been that. It is always “lets look at these different points of view” it is within the structured environment and the client is definitely given control of the situation. I don’t feel, I’ve never felt control has been wrested away from me. Even though I turn myself over to their care, I am in control of my therapy.

Another aspect of encouraging responsibility was that group leaders encouraged members to be open about their feelings and not to displace them onto other group members. Roger shared how his therapist encouraged group members to “own their own emotions.”

Roger: One big tool that the group leaders use is the idea of owning your own emotions and experiencing them. I think there is with that “get to work” thing there is a toughness to the relationship. It ties in with the encouragement thing.

Interviewer: Toughness?

Roger: It sets a standard that it is not ok to put your stuff onto someone else. It sets the standard that it’s not ok to deny your experience.

Ian had a similar experience of being told “let’s get to work.” He found that this simple reminder helped him focus on trying hard in therapy.

In addition to verbal exhortations to be responsible for one’s own work, encouraging responsibility in group was conveyed at first group sessions in which group leaders wouldn’t point the group in a direction. Rather, therapists waited until the group members spoke

before they intervened. Omer shared his experience of how group leaders initiated group members to take responsibility for their treatment.

Omer: Sometimes when we're in group...I remember the first time we sat in group we sit down, introduce ourselves and she is quiet. She doesn't say "well you know Billy, why don't you start talking" or tells anybody to do anything. She just sat there and waited for somebody to initiate group. I'm sure that's probably what she is expected to do, but she does a good job of letting us interact with each other and explore our own issues.

The influence of encouraging responsibility on one's experience of group. Several group members shared that through the encouragement of responsibility, they made a firmer commitment to the group as a whole. Omer described an experience of his group therapists that enhanced his responsibility towards his treatment.

Omer: I think they hold a certain standard of responsibility of oneself to the group. Make sure that if you are not going to show up, call. If you're not going to call, that's looked down upon. It's addressed at the group that you might not be there. They will say XXX is missing, she was supposed to be here and there is an empty chair because of that. You not being there has an affect on everybody else there. I think the second group I missed I wasn't able to attend because of a test. I let her know I couldn't have attended, but when I realized that because I couldn't attend they didn't have enough people and the whole group was cancelled for that day, I felt the need to apologize. I think they hold that standard for the group. That's good.

Essence of encouraging responsibility. Encouraging responsibility is a personal experience that occurs within the group. Therapists encouraged the group members to work

on their issues in therapy. They held them accountable to this and also let them know that group was not a place to put the responsibility for one's treatment onto another person. Encouraging responsibility was shown through words and actions. Therapists would remind group members that it was their responsibility to work, discuss their issues, and own their emotions. They also encouraged group member work by providing a situation in which the group members had to take the initiative (e.g., being silent at the start of sessions). Through encouraging responsibility, group members felt more committed to doing their own group work. They also felt more committed to the group-as-a-whole. They recognized that their individual participation had an influence on the work of the group.

Levels of leadership. Group members noticed varying levels of leadership experience and expertise among their group leaders and this influenced their experience of their relationships and of the group in general. There are three themes within the levels of leadership category. Specifically, the participants noticed the expertise of the leaders, the differences between licensed clinicians and leaders in training, and the dynamic of having multiple therapists work together.

Expertise as an aspect of the therapeutic relationship. The group members found that leaders had a high level of training and experience. With expertise, they were able to understand what group members were experiencing. Multiple group members shared their appreciation of the expertise therapists contributed. Caroline thought that because of her therapist's extensive training that she had, "really wise things to say." Julia had a similar assessment of her licensed therapist's skills.

Julia: I feel like she's pretty much seen it all as far as like counseling. So I feel like she understands me and the situation and she is very open to how I feel and how that's different in my situation than it is in somebody else's.

Beyond a sense of therapists being experienced and wise, group members were impressed with the leadership's ability to recognize and intervene with people who were having difficulties but were not showing it. Liz appreciated that therapists could monitor all the group members to determine if someone was having a bad reaction to what another person was talking about.

Liz: There have been times when people have been freaking out and had really bad problems that they just weren't going to say. But because the group leader was paying attention to the group as a whole and paying attention to the person talking, but also the group as a whole, they were able to catch that and take care of people who ordinarily wouldn't ask for help.

Ian was particularly impressed with the leadership's ability to communicate with each other to coordinate interventions with clients.

Ian: I think we have some extremely well trained clinical staff and their interaction with each other has been remarkable. It's weird. I mean I swear to god they have telepathy.

Although the description of therapists having telepathy was made facetiously, it underscores the impression that the expertise of the leaders made on Ian.

The influence of expertise on one's experience of group. Having an expert made group members look forward to receiving group treatment. Caroline looked forward to group because she was so impressed with the skill level of her therapist. Julia appreciated that the

group leaders had enough skill level to see her as a unique person and not a diagnostic label. If there were no expert group leaders present, group members shared that they would see no point in attending the group.

Caroline also found that the group members changed over the course of the semester following interactions with expert therapists.

Caroline: Group members can learn from the group leaders in that sense like different tactics or questions in group and apply them to other group members so it's real. But the group leaders I feel like are official, it sounds so weird, they have the knowledge.

They are the ones that kinda planted the seed for us.

Caroline appreciated that group members could learn how to intervene like the therapists, but she continued to appreciate the expertise therapists brought to the group every session.

Essence of expertise in the therapeutic relationship. Group members experienced their therapists as having expertise and a high level of skill in therapy. They appreciated that they had a therapist that was skilled to run their group. A particular aspect of expertise that impressed group members was the ability of therapists to recognize when someone needed to speak but had seemingly made no indication of the need. Awareness of the expertise led group members to want to continue with group therapy. They also learned how to interact in new ways by mimicking how the therapists interacted.

Therapists in training as an aspect of the therapeutic relationship. Group members noticed a distinct difference between the licensed therapists and the therapists in training. Multiple participants commented that the therapists in training did not contribute as much as the licensed therapists. Omer shared these observations about the differences.

Omer: It definitely feels like Therapist Z is the leader and the co-leader is more of an assistant as more of the dynamic goes. She doesn't interject as much. Everybody turns to Therapist Z when something that is said might be a little controversial. We look to her to see what her expression would be. The co-leader definitely gives a few pointers as well. But even in post-processing, it's always Therapist Z who is really the main speaker.

Roger noted that the leaders in training were more easily "stirred" by what people shared in the group and Sophie felt like she received less "feedback" from the therapists in training.

Although most participants found that the leaders in training had a limited skill set as compared to the licensed staff, they had a variety of reactions to the differences. Some members disliked that the novice therapists did not contribute with the same skill level as compared to the "expert" therapists. Caroline shared her concerns about the therapists in training.

Caroline: They just kinda reiterate some things. They just say the same thing that another co-leader said. You are like, well, that point is already made and you just kinda reworded it and I think that's wrong.

However, multiple participants did not have a negative reaction. Sophie thought that "it was to be expected" that leaders in training would display a more limited skill set than the licensed staff members. She describes her impressions of her therapist in training in the following quote.

Sophie: I have the feeling that she is still learning the steps. Obviously she probably is, because this is a place where you learn.

Roger not only stated that he understood why the leaders in training were less skilled, but that he liked having them present.

Roger: She is not in the same role so I don't have the same expectations. I appreciate everything she offers. It's like a bridge. She is closer to the student age. That is kind of a cool thought. A bridge between students and leaders.

The influence of having a therapist in training on one's experience in group. Only one participant described how having a leader in training influenced his experience of group. Roger indicated that having a younger leader helped "bridge" a gap that he felt in the group dividing the licensed leaders and the group members. He described how the bridge helped him feel like the group was more coherent and connected. Without a therapist in training he thought that the group members would feel too disconnected from the licensed therapist.

Essence of having a therapist in training. There were therapists in training in the process groups because the university counseling center is a training clinic. The counseling center trains multiple practitioners in group therapy every year, pairing them with licensed clinicians. Group members were ambivalent about having therapists that were in training. The group members recognized that the therapists in training did not have the same level of training and expertise as compared to the senior therapists. The therapists in training would contribute to the group, but their interventions were perceived as not being as skilled as the senior therapists. Reactions varied to having a therapist in training in the group, with some members seeing them as detracting and others appreciating what they could bring to the group.

The influence of multiple therapists on one's experience of group. Though experiencing varying levels of expertise among the leaders, several participants found that

having multiple therapists provide treatment enriched their experience of the group. Group members appreciated having different ways of thinking about themselves. Daria offered the following description of how having multiple leaders enhanced her experience of group.

Daria: I think you tend to see things one way inside your self, and being in group and having one group leader, two group leaders...put their input into your situation helps you see the whole circle of that situation and see everything that maybe you only saw as one narrow thing. They kinda broaden your scope. That's always a good thing I think.

Additionally, several participants found that when the leaders offered different points of view that a dynamic process would take place. Caroline described her experience of dynamic interactions among group leaders.

Caroline: Co-leaders kinda bounce off each other and it works really well because they see other things that maybe Therapist X didn't see or another co-leader didn't see. It makes it kinda dynamic.

In describing a similar experience, Daria used the metaphor of group leaders "building off one another" in order to create an analysis of what was happening that was richer than the sum of its parts. Each of these participants expressed appreciation for having multiple perspectives offered by the therapists.

Essence of multiple therapists. Most groups at the university counseling center are run by multiple therapists. Having multiple therapists conducting group therapy allowed for multiple views to emerge about what a person was experiencing. Group members appreciated hearing different perspectives from clinicians. Multiple views led to new ideas

about what was being discussed. The therapists worked together in such away that their individual analyses of a situation would combine to create a more comprehensive analysis.

Developing understanding. Group members portrayed group leaders as helping them gain a greater understanding of themselves. There were two themes within the developing understanding category including being challenged and making connections.

Being challenged as an aspect of the therapeutic relationship. Group members had a variety of experiences of being challenged by their group therapists. Multiple group members found that the therapists challenged them to help them understand themselves better. For some group members, being challenged by therapists occurred when the group leaders closely analyzed what the members had shared. Ian described this experience.

Ian: At times you feel like a bit of a lab rat. They are picking you apart and trying to figure out what makes you tick.

Ian had to warn himself not to take “personal offense” to being analyzed by the therapists and keep in mind that the therapists were examining him closely in order to help him understand himself better.

Other group members experienced being challenged as therapists critiquing how they participated in the group. Liz offered her own experience of this type of challenging.

Liz: There was a time in therapy when I interrupted someone. I was anxious when I did that. They were saying something and I was like “no no no” and the group leader challenged me for interrupting that person. She said “He is talking.” I felt really bad. I don’t think that was her fault. I was interrupting and I shouldn’t have and she should have challenged me. That was something hard that happened. However, it

made me think “why did that happen, why did I do that?” In some ways it helped me to grow.

The leader’s intervention challenged Liz to think about why she had interrupted. Though an uncomfortable experience, challenging helped her focus on increasing her understanding of herself within the context of group interactions.

Another aspect of being challenged was the way in which it was delivered. Challenges were communicated verbally to the group members. Group members used phrases such as “honest,” “blunt,” and even “harsh” to describe the delivery of the challenges.

In reaction to the blunt delivery, group members found being challenged to be uncomfortable. As noted above, Ian continually reminded himself not take “personal offense.” Dominique shared that he was intimidated by the challenging of group therapists. He shared the following comment describing his therapist making challenges: “It seems like sometimes she’s breaching that comfort zone.” In reaction to seeing the therapist challenge other group members he shared this response: “I just feel for them, like whoa I wonder if they were ready to take that step just yet.” He reiterated several times that people can only share personal information when they feel comfortable in their relationships and that the challenging reduced that comfort.

Fiona talked about how she became frustrated when she could not respond to one of the leader’s challenges. Fiona described a situation in which she had been apathetic about school and she was having trouble understanding why. The therapists posed challenging questions about her apathy that were difficult for her to answer immediately. Fiona offered the following reactions.

Fiona: I hate it when they ask me a question that I can't answer.

Interviewer: What do you hate about that?

Fiona: I don't know. It just leaves me thinking about it when I leave group. I like to be able to answer it right away and figure out how to make it better. If I don't know then it is frustrating. Initially I get frustrated with the leaders but then eventually I see that I am frustrated with the situation of not being able to answer the question.

In this case of challenging, the immediate response to challenging was a negative emotional reaction against her therapists. This was followed by frustration directed at her inability to respond to the challenging questions. Fiona shared that her frustration at herself grew out of her inability to understand why she was apathetic. Challenging did not lead to immediate understanding, but it did highlight the intense desire to understand.

The influence of being challenged on one's experience of group. For most of the participants being challenged was a personal experience between a group member and a therapist. As noted above, the participants felt varying levels of discomfort when their therapists challenged them. However, Daria shared how this experience fit within the context of group therapy.

Daria: When they say "could you explain a little more about that?" That just tells me that there's something that I didn't communicate as well. A lot of times it, it forces me to see things differently or to dive in deeper into something that I wasn't prepared to do. I guess to contradict myself, it is kinda uncomfortable to do that, but it's therapeutic, it's almost what you need to do in group. It's uncomfortable, but it's comfortable.

Daria found that showing her inconsistencies and contradictions was an important thing to do in group therapy. This provided material for therapists to confront and in turn she had the opportunity to gain new insights about herself. As Daria relates, “it’s uncomfortable, but it’s comfortable.” It is a difficult but appreciated experience.

Essence of being challenged. Being challenged was an uncomfortable experience for group members. Therapists challenged group members by analyzing what they had said and critiquing how they interacted with other group members. The delivery of challenges was seemingly harsh and blunt. As a result, it was often uncomfortable. Despite the discomfort, being challenged could lead to a fuller understanding of one’s self. At times it was too uncomfortable for group members to be challenged. They felt uncomfortable with sharing and became upset with the therapists. However, many group members were able to take the experience of being challenged and use it to learn about themselves.

Making connections as an aspect of the therapeutic relationship. Participants shared that therapists helped make connections for them regarding what they had shared. These connections helped them understand themselves and their relationships in new ways. Sophie offered a metaphor to help describe how one of her therapists makes connections.

Sophie: When you are reading a story and one little part of it will come up for you over and over again. The theme of the story goes on. I feel that she is able to pick out those little things that may have not seemed important, may have not seemed that big at the time and it brings it back around to something that ends up being a theme or thread.

Other participants also found that the therapists were able to recall important details and bring them up at relevant times in order to help connect ideas and expose patterns. Several

group members agreed that when therapists revealed themes and patterns of relating that they felt like they understood themselves better. Liz shared that her group leaders had a skill in helping people to develop greater understanding through piecing together different ideas.

Liz: I can tell the group leaders are all really engaged and they are thinking about what we are saying and being able to put it together in a way that reaches conclusions that are often very accurate. A lot of times they are really spot-on with what they are saying.

In the process of making connections, group members found that therapists were able to pick out important ideas and themes and thread them together into a coherent understanding of a situation.

Often the connections provided a label for a pattern or experience commonly engaged in but not recognized or understood by clients. Sophie shared how her therapist helped her see an interpersonal pattern that she unconsciously performed.

Sophie: There was a moment a few sessions ago, 3-4 weeks ago, I was talking about feeling responsible, feeling like I had to take care of everyone I had moved in with. I had moved into a new house and I felt like I was the mother of the house, but I didn't use those words until Therapist X had brought up, she remembered a thing I had said in the past about feeling I was mothering my mother. I took care of her when she was upset. She brought that back and made me realize that is one of the roles I take on a lot, the take care of everyone around you and don't take care of yourself. When she brought that back around, I was really glad that she did because it put something in there that really made me be able to think about this in a new way.

The connections were not about telling clients to do or not to do something. Rather, the connections helped the group members identify an aspect of themselves with which they were previously unaware. For Sophie, she reported that she continued to value the connections made by the therapist's comments.

Beyond appreciating the insights gained through making connections, other participants talked about how they attempted to use connections made for them. For instance, Omer shared a story about how his therapists had offered an interpretation of an issue that had been bothering him during post-processing. He then shared the following response.

Omer: You really think about that, what they are saying. It kinda is circling around your head the whole week after. You notice it when you are doing your regular day to day stuff. I think that is part of the process like "you know what, maybe before this my instinct would have been to feel uncomfortable in this situation, but we talked about this group, maybe I'll just be mindful of the fact that I'm not, I don't need to feel uncomfortable, we'll see how it goes."

Omer engaged with and thought about the connections outside of group. The connection led him to look at a difficult situation in a new way.

The majority of the participants found that they increased self-understanding by having therapists make connections to them directly. However, others noted that they experienced enhanced understanding when watching a therapist make a connection for another group member. In particular, Julia's most memorable experience with her group therapist was one in which the therapist was helping another client make a connection.

Julia: Something that always sticks in my mind, last semester Therapist X was talking to patient Q about how he needs to have a dog, a giant Saint Bernard waiting at home for him, so when he gets home the giant dog just like tackles him and licks him all over the face. Just so he could feel that love, how a dog is waiting for him and be so excited. That mental picture that she put in my head has just stuck with me, it's something that I think about when I come home and my dog is sitting by the door. It just created a connection between how excited my dog gets and the fact that my dog really loves me. Its just reassuring that even if I've had a crappy day my dog is going to be sitting there waiting because it loves me and it's good to feel loved.

The therapist's intervention with another member helped her have a new perspective and appreciation of something in her own life.

Essence of making connections. Therapists help group members connect ideas together. They draw upon what is being communicated in the group and what has been said in the past in order to provide group members with a new perspective on something with which they are struggling. Making connections occurred when group therapists helped group members see a pattern or theme in their lives that they had not previously recognized. It also happened when group members observed therapists making connections for other people. The therapists helped the group members piece together important ideas to formulate a greater understanding of themselves.

Intimacy with boundaries. The group members found that their relationship with the therapists was unique as compared to typical social relationships. They experienced intimacy with their therapists that was marked by boundaries not experienced in other intimate relationships.

Intimacy with boundaries as an aspect of the therapeutic relationship. The group members found that the therapeutic relationship differed greatly from other relationships. Some participants struggled with trying to understand the nature of having an intimate relationship with distinct boundaries. Liz found that being intimate with boundaries made it difficult for her to categorize her relationships with her therapists.

Liz: It's sometimes hard to tell what your real relationship is with a therapist because there is professional caring. It is a weird job because you are empathetic but you also distance yourself. It is hard to tell the boundary, to figure out the nature of the relationship, to figure out the rules in the interpersonal relationship.

Fiona shared her reaction to the differences she saw in the relationship in the following quote.

Fiona: I can't get over it, they know everything about me and I am like "who are you?" They are still a stranger in essence.

Fiona went on to describe how she was able share details about her life that she wouldn't even share with family members, but that she did not know personal details about her therapists. Multiple participants described a pattern in which they knew little about the therapists' personal lives, while at the same time the therapists knew intimate details about them.

Other participants appreciated the boundaries, especially in relation to therapist self-disclosure. Some participants worried that too much self-disclosure from a therapist would distract the group from working on their own concerns. Roger thought that therapist self-disclosure "could be a slippery slope." Ian commented that the lack of self-disclosure seemed to help the therapist focus on the "task at hand." Sophie shared the following quote about

having a relationship with her therapist that was close, but in which she did not know about her therapist's life.

Sophie: I feel like I've known Therapist X for so long in a kind of intimate way and I don't know anything about her life. She doesn't usually bring up, I am sure it is part of the training that you don't bring up things that are your own personal stories. But in some ways that helps not to know that because it feels like her listening is just for me and I don't have to be thinking about what she is thinking about. Interesting to realize that.

In addition to the boundary of limited self-disclosure, participants also commented on how therapists created other boundaries for the group. In particular, participants talked about how therapists discouraged interactions between group members and leaders outside of the group therapy hour. When talking about this limitation on the relationship, most group members found it difficult and uncomfortable. Fiona shared her struggle with limiting interactions outside of group therapy.

Fiona: After having spilled my guts and told all this stuff about me its weird that I can't, there are boundaries that have to be maintained. Like if I see one of my leaders on the street I can't be like "Hi How are you!" I don't feel comfortable doing that, I just do a polite wave and keep going. It's hard for me because I'm super social and outgoing to just say "oh hi" They know everything about me but I just keep going.

Boundaries were expressed in a variety of ways. Therapists told the group members about the limits of the relationship during pre-group interviews and when new members joined an ongoing group. They would also let clients know about the limits of the relationship by not answering queries about their personal lives. They modeled the

limitations with their body language and interactions outside of group. Dominique shared his experience with a group leader limiting interactions outside of group therapy.

Dominique: I saw my group leader one of the other days I was out at a study session at the commons plaza and I saw her and I was gonna wave, but she kinda like pretended like she didn't see me.

The influence of intimacy with boundaries on one's experience of group. Having an intimate relationship with distinct boundaries affected the participants' experience of group therapy in a variety of ways. Multiple participants used the descriptors "awkward" and "weird" to convey their sense of how these relationships made them feeling about interacting inside and outside of a group session. This was especially the case when group leaders did not speak with group members in public. Dominique shared how he felt that he could not open up fully to the group because he knew there were limits on how close he could get to the group members and leaders outside of therapy.

Dominique: That's kinda what is preached, I can see certain levels of it: don't date. Fine lies: don't mix up a hand shake with a hug. I don't know if a hugs too far. I mean I hug people. Just the smallest thing. It is not said specifically, "don't say hi," but it's frowned upon. It's just, "don't interact." Saying "hello" is part of interaction and I don't like that whole thing.

Though admitting that the boundaries and limitations placed on the relationship could make it feel weird, other group members expected it in a professional therapeutic relationship. What is more, some relied on the boundaries for a sense of stability in the group. Julia talked about how she appreciated that she could have a close connection with her therapist but that she did not have to deal with therapist self-disclosures.

Julia: It is helpful because obviously I am talking to 12 other people. It's good to have an emotional attachment to them. It's not the same with the co leaders. It is a one way relationship. With me and the rest of the group it is both ways. They hear my story and I hear theirs. Whereas, with the leaders, they hear my story and help me so they are giving input. But they are not telling me their story. So it's more like they are in the facilitator role of the relationship. They are kinda of helping it along versus being directly really involved.

Essence of intimacy with boundaries. Group members found that they could be very open to their group leaders, but that they knew little about the personal lives of the leaders. In addition to not self-disclosing, group leaders put other boundaries on the intimate relationship. Interactions outside of group sessions were discouraged and physical displays of affection were not allowed. Group members varied in their reactions to having an intimate relationship with distinct boundaries. At times they felt awkward and weird around their therapists. The awkwardness could inhibit open interactions, especially in public. However, others welcomed the boundaries. They appreciated that they did not have to be burdened by worrying about their therapists on a personal level.

Discussion

The development and implementation of the study was guided by two research questions: *How do clients perceive their relationships with their group co-leaders?* and *How do the therapeutic relationships influence the clients' experience of group?* In order to answer these questions the dissertation was set within the interpretivist paradigm (Burrell & Morgan, 1979) because the goal was to describe the subjective experiences of group members regarding their relationship to therapists. To answer the questions I conducted in depth interviews with 10 participants. The interviews were transcribed and analyzed using phenomenological methods consistent with the interpretivist paradigm (Moustakas, 1994).

The study findings provided descriptions of how group members perceive their relationships to therapists and the influence of these relationships on their experience of group therapy. Eight categories emerged from the data including the presence of group leaders, safety, caring, sharing, running group, levels of leadership, developing understanding, and intimacy with boundaries. Each category of experience was comprised of one or more related themes. Throughout the research process attempts were made to uphold the trustworthiness of the study. In line with phenomenological methods (Moustakas, 1994), I engaged in bracketing my assumptions about the study topic.

The study findings suggest a variety of ways in which process group members perceive therapeutic relationships. The results compliment previous literature on the therapeutic relationship in group therapy. I will discuss the findings in relation to relevant literature on group therapy. I will also discuss strengths, limitations, and considerations of the study. Implications for future group psychological research, practice, and training will be offered.

Summary of findings and their relation to the existing literature

Because of the phenomenological approach and interpretivist paradigm employed in the dissertation, its aim was not to confirm or deny pre-existing literature on the therapeutic relationship in group therapy. The aim was to gather a perspective that had not yet been heard. Considering this, it is possible to discuss how the study findings compliment existing group literature. This will create an opportunity to discuss the implications of the research.

Therapeutic factors. Mackenzie (1997) outlined four categories of therapeutic factors that purportedly occur within the group context. Group therapists were identified as being catalysts for these therapeutic factors (Rutan et al., 2007; Yalom & Leszcz, 2005). The categories of therapeutic factors included (1) supportive, (2) self-revelation, (3) learning, and (4) psychological work (Mackenzie). Many of the findings reflect what is stated in theoretical literature regarding the therapist's role in process group therapy. They also suggest complimentary perspectives. The study findings will be discussed in relation to these four categories.

Supportive. Group therapists have a role of helping clients feel safe and supported so that they will be able to participate in group therapy. This is an important factor because research suggests that people are hesitant to engage in and continue with group therapy (Dies, 1994; Ogrodniczuk et al. 2006). The theoretical literature encourages group leaders to prepare clients for treatment, develop an alliance, and create cohesion among the group-as-a-whole (Bordin, 1979; Rutan et al., 2007; Yalom & Leszcz, 2005). The categories that emerged out of the interviews suggest that participants experienced their therapists as promoting support.

The categories safety, caring, and intimacy with boundaries in addition to the themes of facilitation and consistent leadership point to therapists promoting supportive therapeutic factors. The category of safety includes experiences of trusting therapists and being aware of therapist judgment. Because of the trust they felt between themselves and the therapists, participants felt safe about being in group therapy. Through repeated interactions in which therapists did not judge them, participants also felt safer to share. An absence of trust and the presence of judgment led participants to feel less safe about continuing treatment and speaking in sessions. These experiences informed how safe group members felt in therapy, which is an indication of feeling supported. The category of safety reflects Mackenzie's (1997) supportive category.

The caring category also consisted of experiences that relate to being supported. Group members had a sense that therapists genuinely cared about their concerns. In response to the care, they felt comfortable and supported. Therapists showed they cared by empathizing with clients and offering assistance during times of need. The caring experienced by therapists is similar to the bond component of the therapeutic alliance construct (Bordin, 1979). Participants described caring as way in which therapists showed an affective connection. It is interesting to note that the experience of care may have been influenced by group leader gender with female leaders conveying a sense of motherly care.

Research indicates that the alliance construct in group therapy is not a robust predictor of outcomes (see Abougouendia, Joyce, Piper, & Ogrodniczuk, 2004; Constantino et al., 2007; Cortez-Ison, 1997; Crowe & Grenyer, 2008; Joyce, Piper, & Ogrodniczuk, 2007; Lorentzen, Sexton, & Høglend, 2004; Piper et al., 2005; Schwartz, 2004; Sexton, 1993; Taft et al., 2003; van Andel et al., 2003; Westerman, Foote, & Winton, 1995; Woody & Adesky,

2002). Nonetheless, the caring category's similarity to the bond component indicates that one dimension of the alliance construct may be important to group members.

For certain group members, therapists could provide support and safety by offering an intimate relationship with distinct boundaries. On the one hand, group members appreciated the ability to share intimate details about their lives with their therapists. They looked forward to having a chance to tell things that they had never told before. They felt supported by therapists because of the close and intimate nature of their relationships.

On the other hand, group members varied in their responses to the boundaries that therapists established. According to the theoretical literature, group agreements and rules serve to provide a structure that promotes the safety of the clients (Rutan et al., 2007; Yalom & Leszcz, 2005). Group agreements at UCS include no sub-grouping (i.e., engaging in other relationships with group members outside of the group), participating in the group until self-identified goals are met, no physical contact among members, limiting therapist contact outside of group to emergencies, and saying good-bye to group members when leaving group. Limiting therapist self-disclosure, extra-group encounters, and physical displays of affection are implemented to promote the safety and comfort of group members. Several participants appreciated the safety that the boundaries granted.

For instance, during the interview, Sophie realized that having an absence of therapist self-disclosure helped her focus on her own concerns as opposed to the concerns of her therapist. Several participants played with the idea of therapist self-disclosure. Many expressed an interest in wanting to know more about their therapists. Some felt awkward because of their lack of knowledge. Nonetheless, they appreciated the stability that the lack of self-disclosure provided.

Other group members were less comfortable with the boundaries. For some, the boundary of not interacting outside of group hindered their sense of support from their therapists. This indicates that therapists may have established boundaries to promote support and safety, but a person may not react to boundaries as the therapists intended.

Specific themes also fit within the supportive function of group therapists. One of these themes was consistent leadership. Group members used terms like “anchor” and “rock” to describe how they experienced a consistent therapist. They counted on the continuing presence of a consistent therapist because these types of therapists were able to recall everything the participants had shared. The participants appreciated that they could trust in a therapist being at group, week in and week out. The university counseling center from which the participants were recruited has designated time periods in which therapists run groups. Some groups run at the same time with the same leaders for years in a row. Other groups change times and leadership teams on a yearly basis. Depending on a group member’s schedule, she could have a group therapist that was consistently present for the course of her academic career at the university or she could have a different group every semester. From the participants interviewed, it appears that staying with a group with a consistent therapist creates a greater sense of support as compared to switching. Group therapy literature has not examined consistent leadership as a supportive factor, but it appears to be complimentary.

Another theme that resembled the supportive therapeutic factor was therapist facilitation. By facilitating groups, therapists helped the group members work with each other. Therapists connected group members by integrating their stories and encouraging group members to interact directly. The descriptions of therapist facilitation parallel the

literature on therapists promoting cohesion (Bernard et al., 2008; Yalom & Leszcz, 2005). Group theory and research suggest that therapists can help promote support when clients feel a sense of cohesion among group members (Bernard et al.; Yalom & Leszcz). It is important to note that the group members did not discuss experiences of group cohesion extensively in the interviews. This is likely due to the focus of the interviews on the therapeutic relationship. Nonetheless, the facilitation theme indicates that participants experienced their therapists as promoting interactions among group members.

Self-revelation. Mackenzie (1997) writes that the therapeutic factor category of self-revelation is comprised of catharsis and self-disclosure. According to the literature, therapists have the role of helping group members engage in productive self-revelation and refrain from harmful self-revelation (Rutan et al., 2007). For instance, Rutan et al. indicate that therapists can help promote self-revelation by engaging in clarification processes with group members. Therapists might ask pertinent questions about what is being said or done (e.g., tapping a foot) in order to have the client share their experience. Therapists may need to caution members from engaging in self-revelation that could be harmful such as engaging in catharsis early in treatment (Yalom, 1966). The category of sharing that emerged out of the interviews suggests that participants thought that their therapists promoted self-revelation.

The category of sharing consists of three themes: openness, listened to, and right questions. The participants experienced the therapists as being open to and interested in whatever they had to share. They appreciated the openness, especially when they had something difficult to share. Group members also found that the therapists genuinely listened to what they had to share. Knowing that therapists listened led the participants to

share more. Rutan et al. (2007) described how therapists can promote self-revelation through verbally interactive behaviors such as asking clarifying questions. However, it appears that non-verbal processes are also critical to self-revelation. This is in line with theory regarding empathic listening in individual therapy (Rogers, 1957)

In terms of verbal interactions, participants discussed how therapists facilitated sharing by asking the right questions. They were able to ask questions that led group members to share important information that otherwise they may not have known they should share. It is unclear if the perceptions of being asked the right questions were related to ways of questioning or the specific content of therapist questions. Nonetheless, the overall experience of being asked the right question fits with what Rutan et al. (2007) call clarification.

It is important to note that only one participant described experiences with catharsis in group therapy. Dominique shared the following about his group leader. “It seems like she’s trying to evoke emotion out of everybody.” For Dominique, this led to a decrease in his feelings of trust in the relationship and also his ability to share in group. Although it is unclear at what stage of treatment this experience occurred, Dominique’s reactions are similar to Yalom’s (1966) research indicating that engaging in catharsis early in group had negative consequences.

Learning. According to group therapy literature, much of the learning in process groups occurs among group members (Mackenzie, 1997). Nonetheless, group therapists function as educators and or facilitators of learning between group members (Rutan et al., 2007). Two themes emerged from the interviews which imply that participants learned from their therapists. The first theme was that of facilitation. An important component of

facilitation for group members was that group therapists would encourage the group members to interact directly. Through direct interactions, Rutan et al. indicate that the group members can learn from each other. Although no participants talked about learning specific ways to solve problems, it appears that their therapists encouraged the circumstances in which it could take place.

Encouraging responsibility was a theme that complimented the category of learning. Therapists informed group members that it was their responsibility to do their own work. Therapists told participants to “own their own emotions” and that they were responsible for sharing what they needed to share. In other words, they provided instructions for participation. The encouragement served as reminders to group members about why they were in therapy and what they needed to do to make it useful. The descriptions of encouraging responsibility resemble Rutan et al.’s descriptions of therapists taking on a didactic role in therapy in order to teach group members how to communicate in group therapy.

Psychological work. Psychological work in group therapy occurs when group members are able to increase their self-understanding through the examination of interpersonal patterns of relating and individual dynamics (Mackenzie, 1997; Rutan et al., 2007; Yalom & Leszcz, 2005). According to group therapy literature, therapists can promote the processing of interpersonal patterns by examining here-and-now experiences (Yalom & Leszcz). Therapists can also help clients identify their characteristic ways of relating to others (Rutan et al.). Interpreting the transference is another intervention that therapists can engage in to promote psychological work. Through interpreting the transference, therapists can help group members gain new insights (Rutan et al.).

The developing understanding category contained two themes: being challenged and making connections. Both of these themes articulate ways in which therapists engaged in psychological work with group members. Being challenged was a broad theme containing a variety of experiences. One way in which participants felt challenged occurred when therapists analyzed closely what they said. Ian shared how he often felt vulnerable when his words were being analyzed. However, he found that the close analysis led to a greater understanding of himself. Therapists promoted the development of insight (Rutan et al., 2007) through closely analyzing group member statements.

Another way in which challenges occurred was when therapists would confront people about their interpersonal interactions in the group. Liz shared an experience in which her therapists asked her not to interrupt another group member. This challenge led Liz to think about her interpersonal behavior. Therapists encouraged group members to analyze what was happening in the here-and-now (Rutan et al., 2007). Beyond the here-and-now, group members also continued to process the challenges between sessions.

The theme of making connections also revealed how therapists promoted psychological work. Group members found that therapists helped connect patterns and themes together. Out of these connections, group members would gain deeper self-understanding. For instance, Sophie shared the experience of having her therapist identify a prominent pattern of relating (i.e., caring for others at the expense of caring for herself). Sophie was not conscious of this pattern of relating before her therapist made the connections. Sophie was able to increase her understanding of a characteristic way of relating to others through her therapist connecting ideas for her.

Developing insight via therapists making connections also occurred vicariously in group. Julia shared the experience of how a connection made to another group member helped her come to new realizations (i.e., she is worthy of being loved just as her dog shows her). This story suggests that group members can increase insight as a result of witnessing therapist interactions with other group members.

Both being challenged and making connections helped group members towards a greater degree of self-understanding. The descriptions of these themes suggest that therapists engage in psychological work with group members leading to greater self-understanding. Because the study only collected the perspectives of clients, it is unclear what types of interventions therapists were engaging in (e.g., interpreting transference vs. process illumination). Nevertheless, it is undeniable that group members perceived certain therapists interactions as promoting self-understanding.

Structural considerations. In addition to the importance of therapists facilitating the therapeutic factors, group therapy literature identified structural considerations that may influence the therapist-group member relationship. These areas included shared leadership, training groups, and transferring leadership. The relation between the study findings and these areas are discussed below.

Shared leadership. Group therapy literature indicates that there are possible advantages and disadvantages to having multiple therapists facilitate a group. Co-therapists can model appropriate ways of interacting, “work the object,” provide consistent coverage, and reduce blind spots (Kernberg, 1999; Rutan et al., 2007; Yalom & Leszcz, 2005). However, shared leadership may cause damage to the group if they do not trust each other.

The theme of multiple therapists appears to describe experiences that are pertinent to

shared leadership. Group members found that multiple therapists were able to offer a variety of points of view. This appears to be related to therapists reducing “blind spots” (Rutan et al., 2007). Therapists were also able to work with each other to create dynamic interpretations of what was happening in the group. By working together, their analyses were greater than the sum of their individual contributions. This aspect of having co-therapists goes beyond providing consistent coverage. It reveals that having multiple therapists can lead to richer psychological work in process groups.

Training groups. Having an experienced group therapist and a therapist in training facilitate a group can ensure that group members receive ethical treatment and that future group therapists are trained (Rutan et al., 2007). Nonetheless, Rutan et al. caution that having an experienced therapist and a therapist in training run a group can create difficulties. For instance, clients may value the contributions of the experienced clinician more and devalue the contributions of the therapist in training.

The themes of expertise and therapists in training contain descriptions relevant to this area. The participants found that the licensed leaders often displayed a significant degree of expertise. Group members looked forward to treatment because they knew an expert leader would be there to provide expert assistance. In contrast, therapists in training were experienced as being less skilled. Some participants thought this difference was unacceptable. Others expected the difference because of the disparity in training. In congruence with group therapy literature, the participants tended to value the contributions of the experienced therapists over the contributions of therapists in training (Rutan et al., 2007).

Transfer of leadership. Group therapy literature suggests that the loss of a leader and subsequent gain of a new leader can be a difficult experience for group members (Chiang &

Beck, 1988; Rutan et al., 2007). The themes of loss of a leader and new leader speak to this experience. Group members often lamented the loss of a leader. When a leader was lost, the unique contributions of the leader were also lost. It was also uncomfortable to interact with new leaders. It took time for group members to feel comfortable with them. The challenges of experiencing therapists come and go may be uncomfortable, but it also likely stimulates reactions that are important for group members to process, such as loss, sadness, and uncertainty. Group members should have the chance to discuss the loss of a leader and the gain of a new leader (Rutan et al.). This allows group members the opportunity to express what they miss and any apprehension they have about interacting with a new therapist (Rutan et al.). Fiona noted that she is often not able to make final sessions in which good-byes are said. By not having that opportunity, she described how she missed an important experience.

Implications for process group therapy research

The study provides detailed descriptions of how group members perceive their relationships to their group therapists at one university counseling center. Group therapy theory and empirical literature have explored aspects of the therapeutic relationship in process group therapy. This is the first study to examine client perceptions of the therapeutic relationship in process groups using their own words. The study findings provide directions for future research.

The findings suggest that clients perceive their relationship to group therapists as aiding supportive, self-revelatory, learning, and psychological work therapeutic factors. Further research is needed to identify how the relationship can promote the therapeutic factors. Preliminary research may benefit from a qualitative approach using grounded theory methods that aims to develop a theory regarding how the therapeutic relationship promotes

therapeutic factors in process group therapy. Such an approach would allow for the possibility that the therapeutic relationship may promote therapeutic factors that are not included in Mackenzie's (1997) categories. There is also a need for more focused research inquiries that examine the specific mechanisms of the therapeutic relationship in process groups. Examples of such research questions include:

1. What specific interventions do therapists employ to ensure that group members feel like they can trust their group therapists?
2. How do group members develop a sense that their therapists are open to what they share and that they listen to them?
3. What are the differences, if any, in how male and female group leaders express care?
4. Is the experience of being asked the right question related to the way therapists ask questions or to the specific content of their questions?

It will also be important for future research to develop new measures of how group members perceive therapeutic relationships in process groups. Rather than relying strictly on theoretical literature about the therapeutic relationship in group therapy, items could be developed based on the categories that emerged out of this study's data. Responses to these items could be analyzed using exploratory and confirmatory factor analyses in order to see how perceptions of the therapeutic relationships cluster together. Such a quantitative measure would benefit from being developed out of actual client perceptions of the therapeutic relationship in process group therapy. It could be used in research examining the association between the therapeutic relationship and treatment outcomes in process group therapy. Instead of using a therapeutic relationship construct developed for individual

therapy, the measure would represent a process group therapy therapeutic relationship construct.

Another important area of research is the examination of how individual characteristics of process group members and group therapists influence the development of their relationships. The study findings describe how group members with varying perspectives, representing different demographics, and interacting with different therapists perceived the therapeutic relationship. Although my goal was to describe the unique perceptions of the participants, it is important to examine what influences the perceptions. Future research should explore how differences in group member demographics, personality characteristics, and presenting problems influence the development of relationships with group therapists. This research should also consider variances in the individual characteristics of the therapists.

Future research will also need to examine the experience of the therapeutic relationship at different developmental stages of process groups. Depending on the developmental stage, perceptions of the therapeutic relationship may vary widely. Yalom and Leszcz (2005) argue that therapists interact differently with group members depending on the developmental stage of the group. Participants varied widely in the duration of time that they had been in group therapy. Moreover, duration of time does not necessarily correlate with developmental stage. An example of a relevant question is, *How do group members describe the therapeutic relationship during the norming stage as compared to the adjourning stage?* This research would elucidate if group members perceive differences in the therapeutic relationship depending on the stage of group development.

Implications for process group therapy practice

I believe that the study findings are applicable for proposing implications for group therapy practice . First, the data suggests that therapists play a critical role in determining the sense of support and safety group members experience in group therapy. Group members shared multiple ways in which group therapists helped them feel safe enough to be in process group therapy. These findings highlight that group therapists should not underestimate their role in providing a safe and supportive environment. Indeed, therapists should pay close attention to help promote a sense of support and safety for the clients, especially when they may feel challenged.

Consistent leadership was a theme that promoted feelings of safety; it was also not recognized in the group therapy literature. It appears that having consistent leadership provides a sense of stability and support for group members. Group members could benefit from having therapists commit to facilitate one group at a specific time over the course of the academic year. Indeed, some participants appreciated that they could return to the same group, year in and year out, trusting that their group leader would still be there. Admittedly, students have different schedules from semester to semester and thus they may not be able to attend the same group. However, they may alter their schedule if they were aware of the opportunity to continue with the same therapist over the course of their academic career, in addition to its benefits. This is not to suggest that group members must stay in group for years at a time. The findings do suggest that group members who participate in groups for multiple years appreciate working with consistent therapists.

Second, the findings indicate that therapists must be able to balance between interacting directly with group members and encouraging member to member interactions. Participants valued the insights they gained from being directly challenged by therapists or

when therapists made connections for them. However, they also appreciated that therapists were not as involved as they would be in individual therapy. They liked how they encouraged group members to help each other. If therapists did not encourage group member-group member interactions, being in group therapy (as opposed to individual) would not make sense. Therefore, therapists should only intervene directly with an individual when another group member is not able to provide such an interaction. Therapists should also make a concerted effort to engage group members to interact with each other.

Third, the findings reveal that the boundaries that group therapists establish are challenging for the group members. For many participants it was a unique experience to have strict limits on how one was able to interact with another person. A special case of boundaries was how therapists did not engage in self-disclosure. Participants varied in their responses to the lack of self-disclosure. On the one hand, it felt awkward. On the other hand, group members appreciated that it freed them from having to worry about the personal reactions of the therapists. Just because something feels awkward does not necessarily mean that it should be avoided. Group therapists should be aware that clients may respond to the boundaries in a variety of ways. They should give them space to process their reactions to the boundaries. Even if the boundaries are not open to alterations, group members could benefit from processing their experience of the boundaries.

Finally, the findings show that group members value the development of insight gained through interactions with therapists. We live in a world that values symptom reduction as opposed to increasing insight. Fortunately, enhanced self-awareness is still a valued aim in process group therapy (Rutan et al., 2007; Yalom & Leszcz, 2005). Participants greatly appreciated when therapists identified patterns and themes in their

thoughts, feelings, and behaviors that eventually led to enhanced self-awareness. Out of this self-awareness they had the opportunity to make conscious choices about things which were previously unconscious. Therapists should continue to promote the development of insight and self-awareness in process group therapy, especially considering that it may also lead to symptom reduction.

Implications for process group therapy training

The study findings also were relevant to training in process group therapy. Relevant findings include ways in which therapists promoted self-revelation and the influence of the loss and subsequent arrival of therapists in training.

First, participants described a variety of ways in which group therapists helped them feel comfortable with self-revelation. These included being open to whatever was shared, listening and paying attention to the participants, and asking pertinent questions. Notably, the findings suggest that the non-verbal listening is as important if not more important than verbal interactions during the group sessions. Listening to someone speak may help sharing as much as asking questions. This is an especially important notion for therapists in training who may feel the pressure “to do” something. “Doing something” is often incorrectly translated into “saying something.” Therapists in training should develop a balance between intervening verbally and non-verbally. The majority of a therapist’s time is spent listening and tracking the group members. There will be opportunities to intervene verbally whether through questioning or interpreting, but first and foremost, group members need to know the therapists are listening. Therapists in training can take comfort knowing that their attention and presence is often enough “doing” for group members.

Secondly, therapists should keep in mind the influence of joining and leaving a process group; this is particularly important for therapists in training to bear in mind because they are most likely to be the therapists joining or leaving a group. Participants were upset by losing a therapist and immediately having to interact with a new therapist. The transitioning of therapists in training in and out of the group was expected but still uncomfortable. Moreover, the participants felt like they did not have a sufficient opportunity to process the change, even if a final group session was reserved for this discussion.

The discomfort that was voiced underscores the necessity of processing negative affect associated with the loss and immediate replacement. Processing negative affect can be a challenging experience for therapists, especially when they are training. Therapists in training are used to participating in a training experience for a limited amount of time (e.g., two academic semesters). Having therapists in training tell group members that they are being replaced by another therapist in training may *seem* like enough information for group members. It is not enough. The replacement of training therapists leaves group members with the unenviable tasks of losing a relationship and then immediately having to create a new one. Therapists in training seem to want to avoid much of the discomfort associated with their loss.

To address this difficult circumstance, therapists should spend multiple sessions processing an upcoming change in leadership. Group members may not want to engage in the process of saying goodbye. Therapists in training may not see the importance of discussing their impending switch for multiple sessions. Nonetheless, the group members should be given the courtesy of extra time spent processing the loss. Processing the change in leadership for several sessions before and after the switch, would provide multiple

opportunities to explore the reactions of discomfort, anger, and sadness that group members experience. This would encourage an open dialogue about the challenging circumstances.

I do not suggest that therapists should not join or leave groups. Having therapists in training co-lead a group is vital to training future therapists. Moreover, the transition of leadership provides a meaningful opportunity for group members to analyze experiences of losing and creating relationships. Nevertheless, group members deserve the courtesy of discussing this important change with their therapists on multiple occasions.

Strengths, limitations, and considerations

A considerable strength of the dissertation was the use of a research paradigm and methodological approach that fit the area of inquiry. The focus of the research was on describing the subjective perceptions of the relationships that group members have with their group therapists in process groups. The interpretivist paradigm and phenomenological qualitative approach adequately and appropriately address this research area.

There were specific strengths in regards to using a phenomenological qualitative approach. First, there were no formal hypotheses developed about the research area that shaped the data collection or analyses. The semi-structured interviews provided the participants the opportunity to explore and describe their perceptions of the therapeutic relationship in group therapy as they saw fit. This method of data collection was not hypothesis driven; rather, it honored and showed interest in what participants shared.

Second, the design included a variety of trustworthiness strategies including negative case analyses, member checking, use of reflexive and methodological journals, and use of a peer auditor. Additionally, I engaged in a process of bracketing my experience of the phenomenon using the reflexive journal and a peer auditor. The bracketing was an essential

process for me to understand the lens with which I viewed the phenomenon. I learned that my perceptions of process group leaders are complimentary to, but not synonymous with group member perceptions of process group leaders. Enhanced awareness of assumptions and biases allowed for an honest approach to the data analyses. The rigor of the study was enhanced from the multiple trustworthiness strategies employed.

Another area of strength for the study was the sample of participants. The sample represented a variety of perspectives. Participants varied in terms of gender, sexual orientation, presenting problems, academic majors, race, and length of time in group therapy. Overall, the diverse sample allowed for rich and varied descriptions of the therapeutic relationship to emerge from the data.

One limitation of the dissertation was that only individual interviews were employed to collect data. This limited the degree of gathering a comprehensive client perspective on therapeutic relationships in process groups. The use of focus groups would have provided an interesting opportunity gather more data and to explore how the participants interacted with a leader *in vivo*, even though a focus group is not a process group. Focus groups were not employed because of concerns about confidentiality. Focus groups could be an option if multiple participants from a single group did not have to attend the same focus group. This would be possible if only one member was chosen from one group or if the sample size was substantially larger. This was not feasible for the present study. Nevertheless, having one data collection method places a limit on the study findings.

Another limitation was that the study did not account for the influence of the developmental stage of the group on perceptions of the therapeutic relationship. The importance of accounting for the developmental stage of a group is noted above in the

section on research implications. It was beyond the scope of the dissertation to include this important variable. The absence of this variable limits a degree of specificity of the study findings.

Although I consider the composition of the sample to be a strength of the study, it is important to consider the influence of including former members of a process group I had led and non-former members as participants. Including former members and non-former members provided different perspectives on the therapeutic relationship. It is likely that former members interacted with me differently when compared to non-former members. The former members had to navigate the experience of talking about the therapeutic relationship with a former therapist. I believe that they each had a unique response to this situation. Some took the opportunity to discuss our relationship and others refrained from such discussions.

I also interacted differently with former members as compared to non-former members. I was hyper-aware of not wanting to use our previous relationship to get what I needed (i.e., participants). Thus, I was very clear about how participation was completely voluntary and I did not interview anyone with whom I had an active therapeutic relationship. Additionally, I wanted all the participants to feel comfortable expressing their opinions about the therapeutic relationship openly. Engaging in the bracketing process was helpful to me during interviews and data-analysis. It gave me the opportunity to check my assumptions. I firmly believe that each participant gave sincere perspectives on the therapeutic relationship in process group therapy. Nevertheless, one must consider that these perspectives were inevitably shaped by the presence or lack of a former therapeutic relationship.

Relatedly, another important consideration of the study findings is that each participant had personal characteristics (e.g., presenting problem, relationship patterns, &

character style) that influenced their descriptions of the therapeutic relationship. Many group members are referred to group therapy because they have relational difficulties. These difficulties likely colored the descriptions of the therapeutic relationships offered by participants. The area of inquiry was aimed at asking how actual group members currently being treated in process group therapy perceive their therapists. The findings represent the unique perspectives they shared. This was the aim of the dissertation. Of course, generalizability is not the goal of this research because it focuses on respecting the subjective perspectives of the participants and gathering rich descriptions. Nevertheless, with appropriate care the findings are likely transferable to other clinical settings (e.g., community mental health centers) and research designs (e.g., quantitative measure development, qualitative ground theory).

Conclusion

This qualitative study explored group member perceptions of therapeutic relationships in process group therapy offered at a university counseling center. This research compliments theoretical literature and empirical research about the therapeutic relationship in group therapy (Rutan et al., 2007; Yalom & Leszcz, 2005; Bernard et al., 2008; Riva et al., 2004). It offers a unique perspective because it is the first time that process group members have been asked to describe the therapeutic relationship without the constraints of formal hypotheses. In order to complete this task, I employed phenomenological research methods.

Although there were no formal hypotheses, there were two guiding questions constructed in accordance with the interpretivist paradigm and phenomenological methods. The two questions were *how do clients perceive their relationships with their group co-*

leaders and how do the therapeutic relationships influence the clients' experience of group?

The study findings include eight categories of ways in which participants perceived the therapeutic relationship and its influence on group. Each category consists of one or more themes of experience. The categories written in italics and themes written in parentheses include: (1) *presence of group leaders* (consistency, new leaders, losing leaders); (2) *safety* (trust, judgment); (3) *caring* (caring); (4) *sharing* (openness, listened to, right questions); (5) *running group* (facilitation, encouraging responsibility); (6) *levels of leadership* (expertise, therapists in training, multiple therapists); (7) *developing understanding* (challenged, making connections); (8) *intimacy with boundaries* (intimacy with boundaries).

The study findings included a variety of perceptions that group members had about the therapeutic relationship. The findings were discussed in relation to the literature on therapeutic factors in group therapy as described by Mackenzie (1997). The findings were also discussed in relation to pertinent theoretical literature regarding the nature of the therapeutic relationship in process group therapy (Rutan et al., 2007). Research and clinical implications regarding the therapeutic relationship in process group therapy emerged out of the study findings and discussion. Strengths, limitations, and considerations for the study findings were noted.

In conclusion, the study offers a unique addition to the literature on the therapeutic relationship in process group therapy. This is the first study to examine client perceptions of the therapeutic relationship in process group therapy offered at a university counseling center without the constraints of formal hypotheses. The descriptions, which the 10 participants contributed, offer readers increased knowledge of how group members perceive the therapeutic relationship in process groups. This is an important step towards developing a

comprehensive understanding of the nature of the therapeutic relationship in process group therapy conducted at university counseling centers.

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Appendix 1
Demographic Questions for Participants

To help keep confidentiality, please create a name you would like to be referred to when I write up the information you provide in the study.

To help keep confidentiality, please create a name you would like to be referred to when I write up the information you provide in the study.

What name would you like to be referred to as? _____

What is your date of birth? _____

What is your year in school? _____

What is your ethnicity? _____

What is your gender? _____

What is your major? _____

How many sessions have you been in group therapy with your current therapists?
_____ (we will also confirm this number with your therapists)

How many semesters have you been in group therapy overall? _____

What is the presenting problem that you are seeking treatment for? _____

Appendix 2

Interview Stem Questions

The purpose of this study is to examine client perceptions of therapeutic relationships in group therapy. The therapeutic relationship is defined as the attitudes and feelings that clients and therapists have towards each other and the way in which they are expressed (Norcross, 2002).

I want to hear about your experiences with your different group co-leaders in group therapy. I may use questions or prompts to elicit more information from you about your story. I may also ask you to describe your thoughts and feelings about various aspects of your story and topics related to this study.

1. How do you perceive your relationships with your group co-leaders?
(Possible stem Questions) What thoughts come to mind?
What emotions come to mind?
What behaviors come to mind?
2. How do your relationships to your co-leaders influence your experience of group therapy?
(Possible stem Questions) What thoughts come to mind?
What emotions come to mind?
What behaviors come to mind?
3. Please think of a memorable experience you had with your co-leaders in group.
Can you describe the event – what was happening?
(Possible stem Questions) What thoughts come to mind?
What emotions come to mind?
What behaviors come to mind?
4. Is there anything else you want me to know about your relationships with your co-leaders?

Vita

Benjamin Wood was born on January 28, 1982 to Glenn and Kathryn Wood in Montrose, Scotland. Ben and his two brothers and sister were raised in Paris, Maine. Ben was the salutatorian of his high school class.

Ben attended Dickinson College in Carlisle, PA and majored in Latin and Greek. He was involved in numerous academic honor societies including Phi Beta Kappa. He also participated in an improvisational comedy group. He graduated in May 2004 with a Bachelor of Arts degree with Summa Cum Laude distinction.

After graduation, Ben moved to Cambridge, Massachusetts where he attended Harvard Divinity School and graduated with a Masters of Theological Studies in May 2006.

In July 2006 he moved to Richmond, Virginia, enrolling as a graduate student in the counseling psychology program at Virginia Commonwealth University (VCU). He received his Masters of Science in Counseling Psychology from VCU in December of 2008.

In August 2010, Ben will move with his wife, Rachel, to Philadelphia, Pennsylvania to begin his internship at University of Pennsylvania's Counseling and Psychological Services. His research interests are focused on the relationship between clients and therapists.